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ABSTRACT

This final report describes activities and achievements of a project that examined issues in development of coordinated services systems as encouraged by the Individuals with Disabilities Education Act (IDEA) amendments of 1997. It identifies and discusses 27 coordinated services policy and implementation considerations within nine areas. Examples of practices in a number of states are included. Also included are examples of coordinated service plans and other practical information regarding the coordinated services planning process. It notes that coordinated service planning efforts within the states typically involve a hybrid of client-centered, program-centered, policy-centered, and organization-centered strategies. The nine broad policy considerations covered are: (1) vision and leadership, (2) authority and responsibility, (3) scope of coordinated services, (4) identification and evaluation, (5) staffing and skill development, (6) accountability and funding, (7) management of information, (8) teaming, and (9)development of Individualized Education Plans or Individualized Family Service Plans. Appended are outlines of the coordinated services plans for Hawaii and Illinois and sample plan formats from Vermont, North Carolina, Minnesota, Hawaii, and Missouri. (Contains 65 references.) (DB)

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COORDINATED SERVICES PLANNING

by

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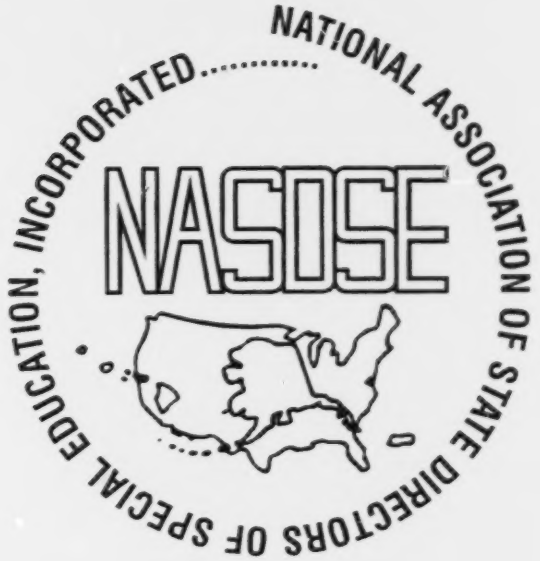

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ABSTRACT

The Individuals With Disabilities Education Act (IDEA) Amendments of 1997 place an emphasis upon improved results for students with disabilities. A coordinated services system is encouraged in order to improve the effectiveness and efficiency of service delivery and accountability for results. Service coordination and case management can facilitate the linkage of Individual Education Plans (IEPs) and Individual Family Service Plans (IFSPs), and other service plans required by education, health, mental health, and social services, including transition services, and related services. This report identifies and discusses 27 coordinated services policy and implementation considerations within nine areas. Examples of practices in a number of states are included within these discussions. Also included are examples of coordinated services plans and other practical information regarding the coordinated services planning process.

COORDINATED SERVICES PLANNING

INTRODUCTION

Purpose of Paper

This paper is designed to provide the reader with background information on coordinated service planning. Coordinated service planning recognizes that children with disabilities and other special needs often require services from multiple agencies. Among its many characteristics, coordinated service planning is needs-driven; has a child and family-centered focus; provides support in the least restrictive setting possible; and includes planning, service, and supports that cut across traditional boundaries of school programs and agencies. In many ways, it is about collaboration in providing integrated services for children and families where agencies add to existing services, modify roles and functions to increase effectiveness and reduce burdens upon families, teachers and administrators while ensuring the best outcomes for children. Coordinated service planning teams can operate at the overall program level to support comprehensive, interagency services and supports, or they can develop coordinated service plans for children and youth with disabilities. Coordinated services plans that are developed can utilize formats that incorporate Individual Education Plans (IEPs), Individual Family Service Plans (IFSPs) for younger children, and other service plans such as the mental health Individual Treatment Plan, or the coordinated service plan can be a separate planning document that is linked with other service plans.

IDEA Provisions

Public Law 99-457, Title I, Section 101(a) passed in October, 1986 (subsequently amended by the 1997 Amendments to IDEA [IDEA '97]) required each state to have a State Interagency Coordinating Council (ICC) to assist the lead agency in the planning of early intervention programs. The ICCs have representation of various agencies within each state involved in the provision of, or payment of, early intervention services to infants and toddlers with disabilities and their families, for the purpose of developing and implementing coordinated service systems. As a result of these IDEA provisions, ICCs across the country have been engaged in coordinated service planning for several years. Although not expressly stated, the IDEA has also supported coordinated service planning for school age children with disabilities.

The need for and value of interagency, coordinated service planning and intervention has been reinforced and made more explicit in IDEA '97. Through IDEA '97, Congress has encouraged state and local education agencies to work collaboratively with other agencies. Section 611(f)(3)(G) allows state education agencies to use funds retained for state-level activities, but not used for administration "to supplement other funds used to develop and implement a Statewide coordinated services system designed to improve results for children and families, including children with disabilities and their families, but not to exceed one percent of the amount received by the State under this section for a fiscal year." Local education agencies may also use up to five percent of the

funds received through IDEA, "in combination with other amounts (which shall include amounts other than education funds), to develop and implement a coordinated services system...." [Section 613(f)(1)]. In implementing a coordinated services system, a local education agency may carry out activities including service coordination and case management, that facilitate the linkage of individual education programs (IEP) and individualized service plans under Part C with individualized service plans under multiple Federal and State Service programs [Section 613(f)(2)(B)].

School-wide approaches are allowed for within IDEA '97 [Section 613(a)(2)(D)], opening up new opportunities for school programs to better mesh and join together for coordinated service planning for students with special needs. Under Section 951, State Improvement Grants will be developed within the states to integrate all restructuring efforts for systemic change, including the development of coordinated services for students with disabilities and their families.

Background of Coordinated Services Planning

The concept of coordinated services can be traced back to the early 1900's when Progressive Era reformers advocated for school lunches, medical and dental inspections, vocational guidance, summer schools to provide recreation especially for urban children, and child welfare workers to work with truant and delinquent youth. After World War II, school social workers and mental health personnel were placed in the schools as an effort to decrease the number of school dropouts. During the 1960s, social welfare reformers began targeting disadvantaged groups (e.g., urban poor, and minorities) and were concerned about assisting children as well as their entire families (NASBE, 1997).

In 1971, the Secretary of Health, Education, and Welfare (HEW), Elliot Richardson spoke about "hardening of the categories" and the duplication in over 500 federal department programs of which 54 overlapped with each other and 36 overlapped with programs in other departments. In the 1970s, HEW funded a number of state-level demonstrations, consolidations, and reorganizations as a part of the implementation of Title XX of the Social Security Act (Kahn & Kamerman, 1992).

During the 1980s, there was increased activity in service integration at the school district, community, state, and federal levels. A number of foundations and national associations were involved in these efforts which continued during the 1990s. For example, the National Association of State Boards of Education initiated the Joining Forces initiative with support from The Ford Foundation, The Joyce Foundation, The Prudential Foundation, and the Johnson Foundation (Levy & Copple, 1989). Joining Forces provided assistance to states and communities linking educational and human services to help families at risk. In addition, fifty national organizations concerned with the well-being of children, youth and families met in 1994 to establish a set of 31 principles to guide co-ordinated service planning at the local, state, and federal levels (American Academy of Pediatrics, 1994). The American Psychological Association (APA) called for service integration and comprehensive and coordinated psychological services for children (APA, 1994). With the needed

emphasis on service coordination, there are changes in roles and responsibilities by school, other social service agency personnel, and parents.

Over the past five years, the Congress and the Department of Education have implemented several initiatives to promote policy flexibility to support new and innovative instructional approaches involving more than one educational program and/or agency (United States General Accounting Office, 1998).

Service integration and coordinated efforts have been directed to both *system delivery* concerns (e.g., coordinated budgeting, policies, and de-categorization of funds) and *service delivery* concerns (such as case management, service integration including family preservation, cross-system family support programs, and coordinated services planning). Kagan, Goffin, Slugg, and Pritchard (1995) have identified four approaches to coordinated services planing. These approaches include:

- *Client-Centered* - Focuses on the point of interaction between service providers and clients (e.g., case management, integrated information and referral, and coordinated services planning by interdisciplinary teams and parents).
- *Program-Centered* - Creates linkages among programs or agencies so that services can more efficiently and effectively serve clients (e.g., creation of planning councils, locating programs together, streamlined application/intake, and pooled funding).
- *Policy-Centered* - Refers to governmental efforts to form linkages between strands of the human service system (e.g., creation of advisory bodies and blended funding).
- *Organizationally-Centered* - Refers to governmental efforts to re-configure relationships between government agencies or offices (e.g., restructuring across departments and programs and reconfiguration of lines of accountability).

Knapp (1995) reported that comprehensive coordinated services range from relatively low-intensity efforts that coordinate the work of different school personnel and other agency professionals to intensive and highly integrated arrangements that plan services and supports for children and families. Coordinated services would be the least intensive end of the continuum while collaboration and joint service planning are at the more intensive end of the continuum. The following is a list of the least intensive (1 and 2) to most intensive activities (6 and 7):

1. Collaborative, joint planning and execution of services in various teaming arrangements where school, agency personnel, and parents develop individual service plans that draw on all disciplines around the table and where various agency professionals and parents carry out planning through joint efforts (e.g., see Robinson, 1993; Hooper-Briar & Lawson, 1994).
2. Enhanced referral of children and families for professional help of one kind or another (e.g., see community-based programs described in Marzke et al. 1992).
3. Coordinated management of cases when children or families require more than one specialized human service (e.g., see James, Smith, & Mann, 1991).

4. Co-location of services, such as health or mental health professionals in a school building—a key feature of "full-service schools" (e.g., see Dryfoos, 1994) or various specialists in a community multi-service center (e.g., see Marzke et al., 1992).
5. Enhanced communication and information sharing among school personnel and providers of different human services through joint databases, liaison activity, and agreements (e.g., see Coulton, 1992).
6. Sharing of resources such as fiscal strategies supporting coordinated services, co-mingling of funds, or pooling of resources (e.g., see Cutler, 1994; Farrow & Joe, 1992; Garvin & Young, 1992; Kirst, 1994).
7. Re-conceptualization of human services by altering the roles and responsibilities such as teachers, psychologists, counselors, other related services personnel in the school, integrated services specialists, parents, and other agency personnel. (e.g., see Wilson, Karasoff, & Nolan, 1993).

Focus and Contents of This Document

Project FORUM, at the National Association of State Directors of Special Education (NASDSE), completed an earlier policy document on School-Linked Services (Ahearn, 1997). In addition, the National Association of School Psychologists (NASP, 1994) completed an assessment paper for Project FORUM which outlined a problem solving assessment approach for encouraging collaboration across school programs (e.g., general and special education) as well as across non-school, interagency programs. This paper is a companion effort intended to assist state and local education agency administrators in implementing coordinated services planning for students with disabilities who require services and supports from multiple agencies.

This document will briefly discuss coordinated services planning, its parameters, and its characteristics. Coordinated service planning efforts within the states typically involve a hybrid of strategies from the four approaches that were identified by Kagan, Goffin, Slugg, and Pritchard (1995) and described earlier in this document . An underlying assumption of this document is that coordinated services planning is more than a plan or document; it is an ongoing planning process. Policy considerations discussed in this paper related to the implementation and support of the coordinated services planning process were identified through a review of the literature and state materials, as well as through a scan of state practices and telephone contacts. These telephone contacts and written materials were made by Project FORUM staff/consultants at NASDSE. Specific coordinated services examples from various states, school districts, agencies, and communities are highlighted to exemplify the various policy considerations. These policy considerations are directed at both broader integrated services planning such as developing interagency agreements, understandings, shared funding, and planning of interagency services (e.g., program-centered), as well as more intense coordinated services planning focused on the child and family (client centered) at the local/community level.

PARAMETERS OF COORDINATED SERVICES PLANNING

Coordinated services planning recognizes that children with disabilities and other special needs often require services from multiple school staff (e.g., teachers, counselors, school psychologists, and other related service personnel) and from multiple agencies. A review of state and local policies reveals that most states have some form of school-linked or integrated services in at least some communities. (First, Curcio, & Young, 1994) Coordinated services planning is being implemented in various forms (e.g., at the state level, the county level, and/or the school/community level) across agencies focused on developing integrated services at the overall program level and/or at the child and family level. These efforts have varying terms in different states and communities including full service schools, school-linked services, integrated services, interagency services, comprehensive systems of care, and various names for interdisciplinary teaming.

Using the above description of coordinated services planning, client-centered coordinated services planning is often paired with program-centered strategies to create linkages across programs by perhaps the creation of a planning council. Coordinated services planning acknowledges the interrelationship between various components of a child's life—physical and emotional well-being, economic self-sufficiency of the family, family stability, and the ability to learn. Coordinated services planning focuses on supports for the "whole child," rather than program by program serving only some of the total needs of the child.

Coordinated services planning at the child level has been referred to as wraparound service planning or individualized service planning with the following characteristics (Markowitz, 1998):

- *Is needs driven, rather than service driven.* The plan should be a combination of existing or modified services, newly-created services, informal supports, community resources, and a plan for a step-down of formal services.
- *Includes a child and family-centered focus.* The parents and child are integral parts of the team and must have ownership of the plan.
- *Provides supports in the most least restrictive setting possible.* Progress is continually evaluated so that the child can be moved into the least restrictive situation that will be of benefit. Supports are offered to enable the child to remain in the least restrictive environment, the first option that is always considered is the child remaining in his/her own family. When residential treatment or hospitalization is accessed, these service modalities are used as resources and not as placements that operate outside the plan developed by the child and family team.
- *Is based on unique strength, norms, and preferences of the child, family, and community.* No interventions are allowed in the plan that do not match the child's needs. The plan builds on the strengths of the child and family.
- *Focuses on typical needs and student/family outcomes in life domain areas that persons of like ages, sex, and cultural background have.* These life domains include family living situation, educational/vocational, social/recreational, behavioral/emotional,

psychological, health, legal, safety, and other case-specific life domain areas such as community involvement needs.

- *Includes supports that are culturally competent.* Supports must be tailored to the unique values and cultural needs of the child and family.
- *Includes a commitment to unconditional care, regardless of whether things go well, by the child and family team and the agency staff who are providing services and supports.* When things do not go well, the child and family are not 'kicked out,' but rather the individualized services and supports are changed to meet the needs of the child and family.
- *Includes planning, services, and supports that cut across traditional agency boundaries.* Multi-agency involvement and funding outcome measures are identified and the plan is periodically evaluated.
- *Includes designing creative programs that meet an individual's strengths and needs.* The service plan is a "living document" that is constantly evaluated and altered in response to the child and family's changing needs and developing strengths.

COORDINATED SERVICES POLICY CONSIDERATIONS FRAMEWORK

As was stated earlier, Project FORUM staff/consultants identified a number of policy issues to be considered when developing and implementing coordinated services planning using program-centered and client-centered interdisciplinary teams. This is a complex topic with many interrelated sub-topics. The following exhibit is included to provide the reader with an overview of the content included within the remainder of this document.

Policy Considerations in Coordinated Services Planning

Vision and Leadership

- Develop a shared vision
- Establish leadership for comprehensive service planning
- Encourage a culture for collaboration within and across agencies
- Consider and respond to student and family diversity

Authority and Responsibility

- Define the governance structure
- Identify/implement changing roles and responsibilities
- Initiate formal or informal interagency agreements or procedures
- Increase authority on the front line

Scope of Coordinated Services

- Determine the primary purpose and scope of coordination
- Define the population to be served
- Define the services to be provided
- Determine the location of interagency services to be provided

Identification and Evaluation

- Identify and implement a single point of entry
- Align eligibility definitions/criteria across agencies
- Use strengths-based assessment

Staffing and Skill Development

- Provide ongoing training and supervision
- Review professional credentialling, staff requirements, other staff issues, and training needs

Accountability and Funding

- Identify a common set of student/family outcomes
- Implement new forms of accountability and systematic evaluation procedures
- Identify and initiate a fiscal strategy

Management of Information

- Establish procedures for information sharing and maintain information in a confidential manner
- Build and implement an interagency management information system

Teaming

- Establish and utilize a team structure
- Implement interagency case management/care coordination
- Expand parent/family involvement
- Allow time for reflection and celebration

Individualized Plan Development

- Utilize a coordinated service plan that incorporates the IEP and IFSP for younger children, or that is linked and coordinated with the IEP or IFSP.

DISCUSSION OF POLICY CONSIDERATIONS

Vision and Leadership

Develop a shared vision - Partners who join a collaborative venture may not have worked together previously. They may not know each other, or they may come from agencies with long histories of conflict, isolation, and possibly competition for resources. They may be trained with different philosophies. In order for a group of diverse individuals to develop a focused, trusting, effective partnership, it is important to find common ground and develop a unified vision for success. A shared vision can express aspirations, goals, and concerns for children, families, and the community. A shared vision can set the tone and direction for the collaborative effort. Planning and implementation should not be dominated by any one agency--education, mental health, or social services. Rather, there must be a collaborative partnership characterized by shared power and respect. Agencies committed to coordinated services planning agree to a set of common goals and directions, share responsibility for obtaining those goals, and work to achieve those goals using the expertise of each agency. Personnel from schools and other participating agencies will need to create an ongoing process to identify common goals and to plan the implementation and evaluation of their efforts.

In developing a vision, it is important to realize that cooperation differs from collaboration. Melaville and Blank (1991) have indicated that collaboration involves the need and intent to change the fundamental way services are designed and delivered throughout the system. Cooperative systems, on the other hand, simply coordinate existing services, even though they are a good starting point for change. Kirst (1991) has indicated that one simple difference between cooperation and collaboration is that in cooperative initiatives, agencies maintain administrative and program autonomy, whereas in collaboration, agencies join together to create options that are no single agency's responsibility.

A shared vision of coordinated services planning can be formalized in state or local policy. Hawaii has developed such a statewide policy on coordinated services planning for children and youth (See Appendix A).

Establish leadership for comprehensive interagency service planning - Melaville and Blank (1991) have indicated that joint ventures sink or swim depending upon the urgency of the problems as well as the willingness of somebody to take leadership. The quality of leadership also greatly influences the process of agreeing on a common goal and developing a practical vision.

The leadership or impetus for initiating coordinated services planning can come from a number of forces. For example, coordinated services planning in Pennsylvania, North Carolina, and Hawaii have come from lawsuits and Consent Decrees. In Vermont, legislation was the impetus for the original Therapeutic Case Management Program intended to reintegrate children and adolescents exhibiting emotional and behavioral disorders into their home communities from intensive residential facilities both in and out of Vermont. Likewise, in Delaware, the State Interagency Collaborative Team was created by the legislature for the purpose of developing a collaborative interagency approach to service delivery for children and youth with disabilities who have needs that could not be addressed through the existing resources of a single agency. The Family Mosaic Project, in Ventura, California, was one of eight national demonstration sites originally funded, in part, by the Robert Wood Johnson Foundation Mental Health Services Program for Youth Initiatives. The North Carolina PEN-PAL project was also created with the assistance of federal funding. The Mental Health Service System Advisory Council initiated the reform plan that originally created the Child and Adolescent Local Area Networks within Illinois.

The Los Angeles Unified School District (LAUSD) initiated school-linked strategies to integrate education, health, and human services as a result of efforts between business and community leaders and the school district board of education and administration. District-wide reform task forces created a blueprint for restructuring pupil personnel services within the 27 school district clusters. Additional federal funding has assisted in the development of comprehensive interagency supports and services, including Family Resource Centers (LAUSD handouts, 1998).

Encourage a culture of collaboration within and across agencies - Staff from the participating agencies must translate shared vision(s) into quality service delivery. It is unrealistic

to assume that all personnel will automatically and effectively implement the goals of the collaborative venture. Virtually any new service delivery effort, particularly involving agencies that staff may be unfamiliar with, will add to staff members' responsibilities and may be perceived as unnecessary or even contrary to their understood roles and responsibilities. The vision of coordinated services planning must be committed to by all agencies involved.

Professional cultures, including professional language and stereotypical attitudes must be examined within and across participating agencies. For example, there may be negative stereotypical attitudes among professionals in one agency about those in other parts of the human service delivery system. Examples might be: "It is time to fix the schools!" or "The real problem is the lack of mental health services!" Attitude changes cannot be mandated. Rather, modeling and positive reinforcement of interagency service planning/implementation must occur. Liontos (1991) reported several staff fears and concerns regarding collaborative ventures: concern about additional workload and overload, fear of not having control over cases, concern that agencies would lose their identity in a collaborative effort, and basic fear of change. How to handle information sharing was another concern reported, as well as turf, power, and control issues. Liontos also reported that logistics can be a problem since interagency service planning requires that staff from participating agencies spend additional time going to meetings with other agencies. The logistics of communication can be challenging. Additional reported difficulties were the time and energy needed to collaborate with additional persons/agencies. Effective interagency service planning cannot be designed overnight.

Liontos (1991) reported the following strategies to solve staff fears, concerns, and problems: get top-level commitment, talk with staff about fears and concerns, help staff feel ownership regarding the interagency planning/implementation efforts, give team members permission to disagree and use conflict resolution as a way of moving forward, try to resolve problems first at the lowest level, bring in neutral parties to help smooth over rough spots, be patient and give collaboration a chance, don't look at resistance as a negative, look at the gains rather than the losses in power and control, send report cards to each other, and create a social service agency coordinator or liaison position. It is also important to talk about successful collaborative planning efforts that have already taken place and where changes might need to occur.

Consider and respond to student and family diversity - Coordinated services should respond to the diversity of children and family--cultural, ethnic, and economic variability. At a minimum, participating agencies must understand and respect, the ethnic, economic, and social composition of the children/families they intend to reach (Jehl and Kirst, 1995).

Stroul, Lourie, Goldman, & Katz-Leavy (1992) reported that all communities studied acknowledged the importance of creating a culturally-competent system of care. The following are examples of some activities reported to be useful in communities to improve cultural competence:

* Attempting to recruit and hire minority staff.
* Providing staff training related to cultural competence.

* Holding retreats devoted to the issue of cultural competence.
* Locating programs or satellite offices in areas that are accessible to minority communities.
* Accommodating the needs of the client population by staying open in the evenings, bringing medical personnel to the program to perform physicals, and holding IEP reviews in the evenings for families.
* Developing programs with a cultural emphasis (e.g., a mentor program in Norfolk which selects and assigns mentors in order to build on the cultural and ethnic strengths in the child's background).
* Ensuring outreach to minority communities by giving to minority agencies, churches and community organizations to educate people about available services.
* Involving key minority community leaders and groups in the system of care in an advisory capacity.
* Establishing a task force comprised of staff interested in issues of cultural awareness and cultural competence.
* Hiring a consultant to assist in the planning process to meet the needs of a particular cultural group (e.g., Native Americans).
* Providing child care during meetings and planning time for parents.

Authority and Responsibility

Define the governance structure - Another consideration when implementing coordinated services is determining who will be responsible. Gardner and Orolove (1994) have pointed out that a choice must be made about governance--whether the school, mental health agency or another entity will be "in charge" of the service planning. Loppez and Weiss (1994) have indicated that the primary authority and responsibility for the governance of school-linked, coordinated services can reside in a variety of places. There is no single governance structure that is the most effective. Once a policy decision has been made regarding the authority base (e.g., designated agency or shared authority), responsibilities related to coordinated service planning need to be agreed upon across participating agencies.

Shaw and Replogle (1995) reported on a data base resulting from research conducted under the auspices of Harvard Family Research Project's New Evaluations Paradigms Project (NEPP) funded by the Annie E. Casey Foundation and the Ford Foundation. Data from this study showed that the most common form of governance involved a shared partnership of school districts and other service agencies (11 of 18 sites studied). Somewhat less common is governance by a separate agency collaborative (3 of sites studies) in which some formal powers were invested in a newly-created governance body. Governance solely by school districts or individual agencies was found to be rare; only two initiatives were adopted by a school district-only governance structure and one resided at another agency. The responsibility for coordinated services planning/implementation may also be shared across agencies. At a minimum, some linkage to school governance is necessary if coordinated services are to be integrated with the regular operations of the school. This necessitates a consideration of the role of the school principal. One or more persons should be identified as

having responsibility and authority that span systems in order to use multiple services effectively. An existing agency structure can be used with agreed-upon lines of authority, responsibility, and communication. Another option is to create an entity with staff physically located away from their home agencies. In Maryland, for example, the governor created a new Office of Children, Youth and Families (OCYF) to plan and implement all interagency activities. While staff are able to collaborate full time with one another in such newly-created structures, the result can be strong commitment from core staff, but weaker participation from the agencies they represent.

Identify/implement changing roles and responsibilities - Initiation of coordinated services planning/implementation will necessitate participating agencies to thoughtfully consider staff roles, selection, training, and supervision. Related services personnel within the schools will have new responsibilities. Staff within various school programs will need to work close together. Teachers, mental health providers, and other providers will need the time, training, and authority to participate in coordinated services planning/provision. Coordinated, interagency service planning requires front-line workers of participating schools and agencies (e.g., teachers and case managers) to become more proactive and inclusive in their interactions with students and their families. Retraining and other staff development efforts are necessary to provide these individuals with the appropriate skills and orientation to view and treat children in a more holistic manner. Each agency has its own culture, vocabulary, schedules, and staff roles that staff from other agencies may not understand or perhaps accept. It may be a difficult challenge for staff accustomed to working in prescribed and comfortable ways to work in an interagency fashion. Interagency service planning/implementation requires a clear understanding of the needs of children and families, use of active listening and communication skills, the ability to build on the strengths of children and families rather than the traditional focus on disabilities, problems, and deficits, and the skills to problem solve in a more creative and flexible manner.

Job descriptions of existing and new staff members should clearly detail assumptions, responsibilities, and expectations for interagency service planning. Melaville and Blank (1993) reported that experience has shown that people most likely to thrive in programs that cross agency boundaries and that "break the mold" include those who:

* Are flexible and creative;
* Tolerate ambiguity and are self motivated;
* Have experience in more than one service sector;
* Genuinely appreciate the strengths of children and families;
* Understand the influence of cultural differences on children and families; and
* Use culture and community values to form service delivery and achieve outcomes.

Initiate formal or informal interagency agreements or procedures - The changes in roles, responsibilities, and methods of "doing business" will impact interagency service planning/implementation. Formal and/or informal interagency agreements or agreed-upon interagency procedures can help resolve a number of issues including governance issues, supervision

and evaluation of staff, which agency's policies to be utilized, process/formats for developing comprehensive interagency service plans for students/families, staff development, provisions for handling conflicts, and procedures for terminating the contract. It is recommended that at each level of service organization, there needs to be agreements (e.g., state policy, school district/community procedures, and school implementation).

Increase authority on the front line - The authority of related services, pupil services personnel, and the other agency partners who work directly with children and families will need to be increased to allow them to make decisions about services without having to wait for approval from other regional or state offices. State commitment will be needed for sharing decision making with the schools and communities. One strategy for increasing authority on the front line, that is discussed later in this document, is to create flexible funding for local determination and use (e.g., used in North Carolina, Vermont, and Illinois).

Scope of Coordinated Services

Determine the primary purpose and scope of coordination - Participating agencies must address and determine the primary purpose(s) of the intended coordinated services planning/implementation. For example, will the purpose be limited to education and mental health? Will the courts and other social services be included within the scope of coordination? Will the IEP planning be separate or will it be incorporated into the coordinated services planning for the child?

Define the population to be served - Participating agencies should consciously define the population to be impacted by coordinated services planning/implementation. For example, the effort may initially target a particular subgroup of the population such as students who are class members to a consent decree, students with emotional disturbance, preschool children, elementary age children, or secondary age students--or all children. Typically, coordinated services planning is provided for those children whose needs require services or supports from more than one agencies. As the population to be served is defined, it will be necessary to overcome different definitions across agencies which often serves as a barrier.

Define the services to be provided - Another consideration to be addressed by participating agencies is a definition of the services to be included within the coordinated services planning effort. For example, will the coordinated services planning target a limited array of services such as counseling or mental health services to deal with behavior and emotional problems, or will the coordinated services planning effort extend to a broader array of programs and supports such as all of the programs and services needed to meet the needs of the child with a disability and his/her family?

Determine the location of interagency services to be provided - A determination needs to be made where coordinated services will be located. Will services be school-linked or school-based? Will mental health and social services personnel work in the schools? The question of service location has both policy and pragmatic implications.

Identification and Evaluation

Identify and implement a single point of entry - Coordinated services planning assumes common or coordinated intake, screening, and assessment. Several streamlined approaches can be used:

Common intake, screening, and assessment forms - A common point of referral is used with each agency utilizing common or coordinated referral, screening, and assessment forms in which eligibility determinations are made in accordance with individual programs within a coordinated services system.

- ✓ The Smart Start integrated services initiative in Genesee County, Michigan, has created assessment, case planning, and permission forms that several agencies are using in their joint service delivery efforts (Melaville, et. al (1993).

- ✓ Ohio began to use a similar form and intake process in 1991 for WIC, Title V Maternal and Child Health programs, the Health Start Program (including extended Medicaid for pregnant women and young children), and its program for children with special healthcare needs. (Kraus & Pillsbury, 1993).

- ✓ Vermont has developed a simplified process that covers WIC, Medicaid, and the prenatal and child health program. (Kraus & Pillsbury, 1993).

- ✓ The State of Hawaii has developed a common identification and eligibility procedures across special education and mental health.

Co-locating Intake and Eligibility - Collocation brings two or more programs Together in a single location to ease access to intake and subsequent services for the children and families.

- ✓ Delaware has long housed together many of its social, health, and other service agencies throughout the state. Income maintenance, social services, public health, mental health, substance abuse counseling, child support, and other staff work in the state's 12 multi-purpose centers.

- ✓ Montgomery County, Maryland built a new multi-service center to co-locate services, bringing health and social services together with a day care center, a public library, board of education offices, community meeting rooms, and a tourist center.

Out-stationing eligibility staff - Staff responsible for screening, referral, and evaluation are housed within the community.

- ✓ Denver's Family Opportunity Program out-stations caseworkers in three community programs to help welfare families move to work.

- ✓ The Wayne County, Indiana, hospital-based, full-service public assistance eligibility offices uses a single cross-trained eligibility worker who completes intake and makes eligibility decisions for welfare programs.

Delegating intake, screening and eligibility authority - Through interagency agreements or common procedures, any agency can delegate the intake and eligibility procedures to another agency.

Align eligibility definitions/criteria across agencies - Different eligibility rules and service parameters can constitute an enormous access problem for children and families with multiple problems. Agencies committed to coordinated services delivery must have common definitions and eligibility criteria. In addition, administrative rules of participating agencies must be reviewed to identify barriers to coordinated services delivery. Interagency agreements or common procedures can be used in which participating agencies agree to certify children and families applying for specific services when they have already been determined eligible for services with similar and more restrictive requirements.

Use strengths-based assessment - Assessment and planning for individualized services should use a strengths-based approach rather than the traditional emphasis on child deficits and personality characteristics. Buchard and Clark (1990) contend that individualized care requires a shift to a more comprehensive, multi-level assessment which examines the social ecology of behavior and attempts to understand youngsters by assessing the total environment in which they function. A strengths-based approach draws upon the assets of the child and family, as well as their needs.

Burchard and Clark (1990) proposed four levels of assessment: analysis of the child and family's strengths; assessment of the broader social environment in which the child and family live; assessment of service needs and available community resources; and assessment of progress and needs on an ongoing basis.

According to VanDenBerg (1993), the strengths-based assessment and planning process for individualized care/education involves examining needs across all life domains including residential (a place to live); family or surrogate family; social (friends and contact with other people); educational and/or vocational; medical; psychological/emotional; legal (especially for children with juvenile justice needs); safety (the need to be safe); and other specific life domain areas such as cultural/ethnic needs or community needs. A comprehensive service plan should be constructed based on the identification of strengths and needs in all life domains. Tannen (1991) also added the need to determine the child and family's perspectives about their needs and what services and supports they desire. Friedman (1988) stressed that an ecologically-oriented assessment focuses not

only on the child's problems, but on strengths and interests and helps an interagency team move away from a "placement" orientation and towards a "planning" orientation.

Staffing and Skill Development

Provide ongoing training and supervision - An investment in training will pay rich dividends in more effective interagency service planning/delivery. Ongoing training and supervision will be necessary to fully implement the coordinated services vision into everyday practice. Coordinated services planning will require an ongoing commitment to staff training/development. Training will be needed regarding the roles of staff in other participating agencies. Front-line staff will need to "unlearn some of the attitudes and behaviors common in highly bureaucratic, agency-centered, problem-oriented institutions. (Melaville & Blank, 1993) Staff will also need training that teaches them to "examine their own cultural beliefs and child-rearing values and recognize the tensions that can arise in programs that seek to empower families" (Melaville & Blank, 1993). Ongoing training can help staff develop a sense of identity and ongoing commitment to the vision and goals of interagency service planning/implementation. Teachers, related service personnel (e.g., psychologists and counselors, and other agency personnel) will need to be interdisciplinary. To that end, they will need to know what other disciplines can contribute to solutions for issues confronting children and youth with disabilities and their families. Training must go outside of traditional discipline lines. Other training considerations (APA, 1994) include:

- The need to train teachers, related services personnel such as school psychologists and counselors, and other agency staff who may be trained in subdisciplines with limited knowledge of the activities and skills of related disciplines involved in coordinated services.
- School staff (e.g., teachers and related services personnel such as school psychologists and counselors) may not have been trained to collaborate effectively with medical, educational, and social services personnel. Likewise, other agency personnel may also have the same training concerns.
- Coordinated services planning will require interagency staff training for broader tasks that go beyond individual program areas.

Ongoing training is essential that goes beyond one-shot workshops and includes on-the-job mentoring. The most effective training that can be provided is facilitated actual intra and interagency teaming experience, including experience developing coordinated service plans for children/youth with complex needs requiring services from several agencies.

Review professional credentialing, staffing requirements, other staff issues - Participating agencies should review their professional credentialing and staffing requirements--both formal and informal rules and policies. For example, school counselors must be able to work freely across both education and mental health settings. When two or more agencies come together in a collaborative effort, they frequently bring with them differing staff pay scales. This issue must be dealt with so that disparities in salaries do not result in staff resentment. Likewise, mental health professionals

must be able to interact with the child's educational program. Job descriptions may need to be revised. In addition, caseload and classroom assignments must encourage and allow staff flexibility to work with staff in other agencies. Staffing for coordinated service planning needs to be sufficient to allow for time to collaborate and to plan as well as to carry out care coordination responsibilities.

Accountability and Funding

Identify a common set of program and student/family outcomes - Traditional accountability systems provide rewards for procedural compliance with rules and regulations (Kirst, 1990; Kahne and Kelley, 1993). Holistic, interagency service planning should be based on outcomes-based accountability, in which the schools and other social service agencies are evaluated in terms of specific measures of child or family health and cognitive or emotional growth. Participating agencies must deliberately select outcomes that are targeted for improvements in the way services are planned and implemented in a coordinated, "whole child/family" approach. Outcomes should be identified early in the implementation of interagency comprehensive service planning/implementation. Pittman & Cahill (1992) have recommended the following student outcomes/competency areas for consideration in coordinated service planning: health/physical competence, personal/social competence, cognitive/creative competence, vocational competence, and citizenship competence (values and participation). Schrag, Groves, & Foster (1998) identified the following child status indicators, service system performance, educational status indicators, and social status indicators:

Indicators of Child Status

- Safety
- Stability
- Permanence (e.g., goal and plan for living in the home and community)
- Caregiver/service provider functioning
- Restrictiveness (e.g., services provided in the least restrictive, most appropriate placement)
- Health/physical well-being
- Emotional/behavioral well-being
- Learning progress
- Personal responsibility (e.g., skills, attitudes, and habits necessary to function independently and responsibly within the home, school, and community).
- Satisfaction with services and supports received
- Overall child/family status

Indicators of Service System Performance

- Child/family participation
- Functional service team functioning
- Comprehensive assessment
- Long-term view (e.g., successful functioning in the home, school, and community over time)

- Evidence of a single, unified, cross-agency Individual Service Plan (ISP)
- Resource availability to carry out the ISP
- Plan implementation
- Caregiver/service provider supports
- Extent of timely and effective urgency response
- Tracking/adaptation of the ISP
- Level of effective coordination and continuity in the provision of services to the child and family

Educational Status Indicators

- School attendance
- Classroom participation
- Completion of assignments
- Responsible behavior/good conduct
- Academic performance (grades)
- Achievement/assessment
- Portfolio or alternative assessment
- Progression in general education curriculum
- Grade level promotion
- Participation in extra-curricular activities
- Work experience
- Graduation/work/post-secondary education
- Follow-along plan education
- Effective results produced via services planned for the child/youth

Social Status Indicators

- Identify responses that connotes a feeling of personal worth
- Belonging and affiliation with others in the child/youth's support networks
- Being capable of participating in major life activities and decisions that affect him/her
- Being part of his/her culture and social supports
- Responsible community behavior

Related to overall program outcomes, activity logs, staff time sheets, case records, interagency memoranda of understanding, logs indicating requests for services, satisfaction interviews/surveys, and interviews with staff and program participants are some examples of strategies that can be used to help trace how students and families interact with coordinated services.

Measures should be reasonable and should relate to available data. Commitment is needed for the collection of evaluation data over a sufficiently long period of time. A comprehensive evaluation plan needs to track the process of interagency service planning/implementation and the outcomes. Since coordinated interagency planning requires the cooperation of a wide array of individuals (e.g., teachers, related services personnel, school administrators, social service agency

administrators, front-line workers, parents, community groups, etc.), evaluation will have many audiences. In selecting evaluation methods/procedures, the concerns of each of the stakeholders must be adequately addressed. Issues of confidentiality also needs to be considered.

The Center for Mental Health in School (1996) recommended consideration of the following outcomes:

- ✓ Student outcomes (e.g., outcomes reflecting enhanced receptivity to instruction and outcomes related to preventing and correcting emotional, behavioral, learning, and health problems);
- ✓ Outcomes related to intended impact on families and community, with particular emphasis on health and safety; and
- ✓ Outcomes related to intended impact on programs and systems. Such outcomes include those that promote and support a major restructuring of school support services, integration of school support services with other school-based/linked support programs, outreach to enhance linkages and collaborations with community resources, and integration of all activity designed to address barriers to learning with the instructional and school management components.

Implement new forms of accountability and systematic evaluation procedures - New standards of accountability will need to be developed for every level of staff in the participating agencies. Measures of accountability to be used should emphasize the achievement of positive outcomes rather than dictating specific inputs and the need for compliance on forms and procedures.

Participating agencies should be both willing and able to collect data about what is attempted and achieved and at what cost. Ongoing evaluation (e.g., daily, weekly, and monthly) can help determine how well joint service planning is working and what mid-course corrections will be necessary to make it better.

Identify and initiate a fiscal strategy - A fiscal strategy may be required to support new core funding for staff and services necessary for the collaboration. Re-deployment of existing funds may also be necessary. There may be a need for relaxing categorical requirements for funds across agencies. Farrow and Joe (1992) have suggested the following assumptions about funding mechanisms to support coordinated services:

- Family-oriented (e.g., responsive to a child's needs in the context of family and community).
- Comprehensive and flexible in meeting the unique needs of the child and family.
- De-centralized in terms of placing decision-making authority within the community and at the school and neighborhood level, rather than in state human service agencies or in the central offices of school district.
- Prevention-oriented in terms of emphasizing developmental services and services that spot problems early and support families when they first seek help and seek to avert crises.

- Outcome-focused, attempting to measure success by gauging children's progress in school and a family's ability to help their children succeed.

Re-direction or Re-deployment of Funds - A fiscal strategy that utilizes existing funds for a different purpose or activity.

✔ The Alaska Youth Initiative has used a re-deployment funding strategy with the goal of returning youth who had been placed out-of state and back into their community. The Alaska Youth Initiative has provided broad-based authority to multi-disciplinary teams to re-deploy out-of-state placement funding to assist in the design of more community-based treatment program.

✔ Tennessee's Children's Plan introduced a new funding approach--diverting funds spent for out-of-home care (foster care, group homes, and residential treatment) and financed intensive family preservation services, which are crisis intervention services for families at imminent risk of having a child removed from the home. Programs have been funded jointly across agencies with each agency contributing a share of the cost. State agencies have been required to pool all funds previously spent for out-of-home care into one statewide account under the control of the Department of Finance and Administration. These funds have been flexibly used to finance plans of care developed for children and families through a redesigned system of Community Health Agencies responsible for assessing the needs of all children at risk for out-of-home placement and for prescribing services that might prevent placement.

✔ Some states are experimenting with budget redirecting strategies to support integrated services. For example, Maryland enacted legislation to give local jurisdictions the authority to use funds appropriate for out-of-home care to provide in-home services for vulnerable children and families. This new funding strategy has an emphasis on community decision-making and planning rather than state-level micro-management, movement toward less rather than more categorical services, and incentives for localities to design less costly in-home and community services rather than expensive residential placements.

✔ In several states, family preservation services have been financed through re-deploying funds that had been appropriated for out-of-home care. California legislation enacted in 1988 has allowed counties to shift up to 10 percent of the state's share of foster care expenditures to placement prevention services such as family preservation. At least twelve counties have participated in this re-deployment process. Specifically, an incentive has been created for reducing savings in foster care expenditures.

Cost Sharing/Blending of Funds - Stroul, Lourie, Goldman, & Katz--Leavy (1992) reported on several communities that had blended funds or initiated forms of cost sharing to support the development and operation of specific components of their systems of care. Home-based services, day treatment, therapeutic foster care, and case management are examples of services funded by two or more agencies at some sites. In several communities, provisions have been made for multiple agencies to participate in financing the service plan designed for a child and family.

- ✔ In Richland County, Ohio, agreement has been reached among the participating agencies regarding their relative contributions to support a service plan designed for a child and family.

- ✔ In Northumberland County, Pennsylvania, treatment plans have been jointly funded by the various agencies with each picking up the costs of care falling within its jurisdiction.

- ✔ Another approach has been adopted in Stark County, Ohio, involving the creation of an interagency funding pool (with a formula to govern contributions from participating agencies) that has been used to fund plans of care and to cover the administrative costs of the Interagency Cluster.

- ✔ In Florida, cost sharing has occurred to support Family Service Plans developed by Family Service Planing Teams within each of the Health and Rehabilitative Services Districts. Cost sharing has been a cooperative venture to meet the needs of the child based on available resources including but not limited to the school, the parents, and Health and Rehabilitative Services.

Maximizing Third Party Resources - Stroul, Lourie, Goldman, and Katz-Leavy (1992) reported that all the communities studied were exploring strategies for increasing third party reimbursements for services included in their systems of care. The primary focus of these efforts has been on Medicaid, with communities working diligently to increase the range of services and providers eligible for Medicaid reimbursement.

- ✔ In 1992, California adopted a state policy of "realignment" which transferred resources for health, social services, mental health, and substance abuse from the state general fund to a local trust fund in order to provide counties with a greater degree of financial control and stability.

- ✔ Kentucky has attempted to develop a stable program of school-linked service delivery by implementing Family Resource and Youth Service Centers as a part of the Education Reform Act of 1989. Although the amount provided to school districts and communities has been small and intended to

supplement other funds, the original intent was to support core social service staff.

- ✔ In the San Diego's New Beginnings Program (Levy & Shepardson, 1992), staff have been re-assigned. For example, social workers previously reporting to the Department of Social Services have been out-stationed to serve families in a school.

Flexible Funding - This fiscal strategy allows communities to utilize resources to be used to meet needs other than their previous, intended purposes.

- ✔ A major aspect of North Dakota's Children and Family Services Reform Initiative in two regions of the state has been the provision of flexible funds at the front-line worker level to meet unique family needs. Family workers can expend on their own authority up to $250 per family for nontraditional support items such as emergency child care, emergency food, alcoholism treatment, automobile repairs, or rent deposits to help stabilize families

- ✔ In a number of states, family-support subsidy programs provide flexible funds directly to families to use for children with disabilities. In Michigan, over $15 million has been available statewide to provide support for families who care for their own children rather than having to place them in group homes or other institutions. Families have used the funds to purchase respite care, home nursing services, ramps, or other items to avoid out-of-home placements.

- ✔ In 1993, the Illinois legislature provided funds that had been allotted for room and board (e.g., residential care) to be used for the creation of community-based programs providing alternatives to residential placements. These funds have been provided to 62 Local Area Networks by the Illinois State Board of Education to be used in a flexible pool of funds to provide non-categorical, creative services to identified children and families. The focus of the planning has been based on the wraparound concept.

- ✔ In Virginia, an innovative new funding mechanism was adopted with the passage of the Community Services Act in 1992. This legislation combined eight major funding streams for services to children and adolescents and gave communities the flexibility to determine how resources are spent. The funding pool has been administered by local interagency teams. In addition, a new state trust fund was established to support localities in expanding their service arrays.

Leveraging Other Funds - Leveraging private sector and foundation funds is another way to expand the funding base for services or to cover the start-up costs for system

reform. The Robert Wood Johnson Foundation has been working with a number of local sites on a comprehensive children's health initiative that seeks to better connect a wide range of children's services.

The Anne E. Casey Foundation has developed several state and community initiatives that support systems to become more responsive to families, more community-based, and more cross-disciplinary. The New Futures Initiative, for example, has supported collaborative efforts in several cities to connect education, employment, and other youth services to reduce school drop-out rates, adolescent pregnancy, and youth unemployment.

The Pew Charitable Trust's Children's Initiative has had a ten-year partnership with several states to develop a system of inclusion for young children that is neighborhood-based, school-linked and family focused. This Initiative has supported the development of family centers that can assure that family needs are met through both public and voluntary systems of support

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In addition to national business and foundation support, many community foundations have provided support for comprehensive, interagency service planning--local United Way agencies, Kiwanis International, and the Cooperative Extensive Service.

Maximization of federal funding - Another approach being used by a number of states and local communities is maximization of federal funding such as creative use of Medicaid funding to support services including physical therapy, occupational therapy, speech therapy, and case management.

De-categorization - De-categorization is another strategy being used (e.g., reducing and removing categorical strings attached to funding so that funds can be spent according to another set of priorities). De-categorization can free funds from narrow limitations of categorical programs to allow a more responsive array of services for children and families.

In 1987, the Iowa General Assembly passed legislation directing the state Department of Human Services to select two counties as demonstration sites for de-categorizing child welfare services in order to develop client centered services rather than funding stream driven services. Iowa's de-categorization initiative has involved consolidation at the county level of more than 30 separate state funding streams. De-categorization has provided an opportunity to develop a more coherent set of school-linked social, health, and education services. Subsequently de-categorization has been expanded to additional six counties and received permanent statutory authorization. De-categorization of funds has allowed redirecting funds previously used for institutional services toward community-based services. Redirecting of

funds has also helped to develop integrated service plans for families who have been high cost users of the system.

Management of Information

Establish procedures for information sharing and maintain information in a confidential manner - Strategies must be implemented to allow sharing of information. Confidentiality requirements can make sharing appropriate data about children among schools, health providers, and social services agencies impossible or very difficult. Barriers to confidentiality requirements need to be identified with changes to alleviate these concerns. In determining solutions to information sharing barriers, it is important to understand that there are confidentiality values to protect and enforce. State policies will need to be identified that allow for joint data collection and exchange of relevant information to support coordinated action, while respecting legitimate privacy rights.

The Center for Mental Health in Schools in Los Angeles (1996) has provided an introductory packet on confidentiality and informed consent. The reader is referred to this document for an in-depth discussion of information regarding this topic that would be helpful in the formulation of state and local confidentiality and information sharing policies. Following are several pertinent points provided in this information:

- The interests of children and families in protecting private information from unauthorized disclosure are significant and should not be disregarded (e.g., the core interest in privacy, avoiding exposure of information, avoiding embarrassment or prejudice, and protecting personal and family security).
- Balanced with these interests in privacy are the interest of agencies in sharing information (e.g., related to conducting assessments, developing service plans, monitoring the prevision of services, making services family focused, and securing full federal and state reimbursement).
- Some information that does not identify specific individuals is not confidential and may be shared freely.
- The most common way of information-sharing is through informal exchanges, verbally and by telephone between workers who have developed a high degree of trust and cooperation with the parents.
- Most statutes explicitly authorize a certain degree of information-sharing without consent of the individual (e.g., for administrative purposes, audits, determinations of eligibility for services, medical emergencies, and other pertinent investigations).
- Virtually all statutes authorize information-sharing with the consent of the client.
- Agencies may enter into agreements for sharing information among agencies.
- In using aggregate information systems such as automated information systems containing identifiable information, protective mechanisms must be in place to ensure proper disclosure of confidential information.
- Agency workers have the responsibility to comply with whatever established procedures for information sharing and confidentiality exist.

Client and family information discussed or distributed at interagency service planning meetings is considered confidential. Typically, a single release form is used to obtain the consent of the parents for the exchange of information among the specific agencies involved on the interagency team.

Stroul, Lourie, Goldman, & Katz-Leavy (1992) reported that most of the communities that they studied had developed a common release form that allows participating agencies to share information. Typically, the case manager or the staff person from one of the involved agencies takes the lead in approaching the parents to explain the interagency service planning and intervention process and requests that they sign the release. In Richland County, Ohio, for example, copies of case records which have been shared in preparation for service planning meetings or case review are placed in the center of the table to be shredded following the discussion. When dealing with confidentiality consideration and procedures, the requirements of Part B, IDEA and the Family Educational Records Privacy Act (FERPA) need to be met.

Build and implement an interagency management information system - Many child-serving systems maintain electronic information on the children they serve (e.g., New York, Texas, Pennsylvania, and Illinois). To use information flexibly, interagency partners engaging in coordinated services planning should consider implementing a management information system or a centralized data bank that stores individual and aggregate data and information about organizational systems. An automated system can:

- → Allow schools and agencies serving the same families to share information;
- → Access information from other agencies and add information potentially useful in designing, implementing, or following up on service or educational plans;
- → Identify information needed to establish eligibility for services;
- → Verify what services families currently receive and determine whether they actually received services to which they were referred; and
- → Establish ongoing records that make it possible to follow a child and family from one agency or community to another to prevent service interruption.

An effective MIS should also permit the retrieval of aggregate data for tracking accountability-related information on caseloads, resource use, costs, outcomes, and related factors. Partners can then analyze this information to identify problems and to track progress toward key indicators of child and family well-being. In the development of an interagency MIS, the requirements of Part B, IDEA, the Family Educational Records Privacy Act (FERPA), and other applicable federal laws governing other agencies are applicable.

Teaming

Establish and utilize an interagency team structure - In their nationwide survey, MacFarquhar and Dowrick (1992) found that interagency team collaboration was the most frequently-reported factor leading to the success of individualized services (e.g., 93 percent of the programs surveyed used an interagency team approach to providing services). Their findings

indicated that this interagency team includes the persons most involved in the child's life and the child (depending upon age and maturity level). The interagency team may be the same team that develops the IEP or IFSP if a coordinated service plan is developed that incorporates the IEP or IFSP. The interagency team may also have a different composition if the coordinated service planning is separate from the development of the IEP or IFSP and focuses on the broader social and health services that will be coordinated with the child's educational services. VanDenBerg (1991, 1993) specified the following composition of an interagency service planning team:

- The parent and/or surrogate parent (i.e., foster parent, therapeutic foster parent or guardian);
- The appropriate representative of the state (social worker or probation officer) if the child is in custody;
- A lead teacher and/or vocational counselor;
- The appropriate therapist or counselor, if the child is in mental health treatment or should be in mental health treatment;
- A case manager or services coordinator who is responsible for ensuring that the services are coordinated and accountable;
- An advocate of the child and/or parent;
- Any other person who may be developing effective services such as a neighbor, a physician, a relative, or a friend; and
- The child, unless to do so would be detrimental to the development of the child.

Katz-Leavy, Lourie, Stroul, and Zeigler-Dendy (1992) have reported that interagency teams have been given a wide range of terms including individual support team, interagency treatment team, core services team, family assessment and planning team, individual support team, community support team, creative community options team, and others. Katz-Leavy et al. (1992) indicated that despite the range of terms used, the role of the interagency service planning team is consistent across states and communities. The case manager plays a facilitative leadership role, and the team meets/works together over time to develop and implement a comprehensive, individualized service plan for the child and family. The comprehensive service plan is holistic and addresses all of the child's life domains. The team monitors progress and revises the plan based upon the child's changing needs and progress/lack of progress. The focus of the interagency service planning team is to reach consensus across agency participants on the services and supports needed by the child and family and to design, provide, monitor, and revise the individualized service plan as needed. Experience in a number of states and communities indicates that both a child-specific interagency service planning team and an interagency entity that focus on system-level issues appear to be essential elements to an effective system of care (Katz-Leavy et al., 1992).

Multi-agency teams typically are organized by the case manager and are composed of the persons most involved with the child/family. With the case manager playing a facilitative leadership role, the team meets and works together over time to develop and implement a comprehensive individual service plan for the youngster and family which addresses all of the child's life domains. With the facilitation of the case manager, the team continues to monitor progress and to reconfigure the service plan and approaches based on the child's changing needs. These types of service

planning teams are increasingly being used as an integral part of the case management process. These planning teams are used for those with the most complex and challenging problems.

- ✔ Florida's Family Service Planning Teams (FSPT) are standing interagency groups with core members and supplemented with persons specific to the child for whom an individualized service plan is being developed. The Family Service Plan Team is a multi-agency/multi-purpose team comprised of core members (e.g., representatives from the Alcohol, Drug Abuse and Mental Health Program and the Children, Youth, and Families Program of the Department of Health and Rehabilitative Services, the Exceptional Student Education Department from the county where the child is attending school, representative from the Severely Emotionally Disturbed Network, SEDNET, and other provider agencies such as a community mental health center and a community substance abuse provider). In addition, the teams include child-specific significant others who convene to assist parents/guardians, or caregivers in securing the least restrictive, most relevant, most culturally competent, and appropriate services necessary to keep their child living in a home and the community.

  Functions of the team include reviewing referrals for an array of services and developing, monitoring, and evaluating the Family Service Plan. The team ensures that the parents' assessment of their problems and needs is fully considered in the plan development. The team helps parents prepare for a FSPT monthly meeting since they participate directly in the development and implementation of the service plan. The team ensures services only to the intensity necessary to eliminate the specific problem areas identified in the family service planning process, with emphasis on maintaining the dignity of the child and family. The FSPT uses community-based, non-residential resources to maintain the child in the least restrictive environment and to ensure the ability and likelihood of family participation.

- ✔ During FY 1991-1992, the Delaware legislature established the Interagency Treatment Planning and Service Delivery Team. The name of this group was changed to the Interagency Collaborative Team (ICT) and includes representatives of the state agencies serving children as well as the State Budget Office and the Office of the Controller General. The ICT is charged by the legislature to develop a collaborative interagency approach to service delivery for children and youth with disabilities who have needs that cannot be addressed through the existing resources of a single agency.

- ✔ Illinois has implemented a standing group known as the Interagency Management Team (IMT) comprised of representatives of the State Board of Education, Department of Mental Health and Developmental Disabilities, the Department of Children and Family Services, the Department of Alcoholism and Substance Abuse, and the Department of Corrections to assist in the evolving process of Child and Adolescent Local Area networks in response to the Governor's challenge to reform

mental health and social welfare services in Illinois (e.g., improve and streamline service provision and access to services for children and families in Illinois).

- ✔ Olson, Whitbeck, & Robinson (1991) have reported on an approach used in Washington State in which an interagency coordinating mechanism (ICM) has been used that is made up of administrators from each of the child serving systems. An individual support team has been organized to develop and adjust individualized "tailored" services. This multi-tiered system of interagency collaboration is an example being used by an increasing number of communities in which client-level functions are separated from system-level functions. (Katz-Leavy et al., 1992).

- ✔ The legislation in Illinois in 1991 created a State Interagency Team made up of heads of the agencies serving children, a parent, and other program specialists/consultants. This team was charged with developing a system of care. Local interagency teams were also implemented to develop and review coordinated services plans for children and adolescents with emotional disturbance.

- ✔ Youth Service Teams in Linn County Oregon (1997) have provided ongoing interagency cooperative collaboration between the schools, social service agencies, law enforcement agencies, and other relevant community resources. Agency representatives and family members meet together to share information, explore alternatives and develop a plan of action to meet the child and family's needs. This process has been effective in developing a coordinated community plan, maintaining children in the community, preventing the need for institutionalization, preventing duplication of resources, and increasing understanding of agency involvement and planning.

- ✔ Vermont had used a multi-thread system of interagency collaboration. Child-specific interagency treatment teams have been formed to develop individualized plans for children. If there are difficulties in resolving funding, program, or policy issues in the development or implementation of the individualized plan, the case is referred to the second level of the local interagency team. The State Interagency Team is available in those instances that cases cannot be resolved at the local interagency team level. (Katz-Leavy et al., 1992).

- ✔ A three-tiered system has been developed in Stark County Ohio for individualized planning and review. A Creative Community Options team has been organized for each individual child and family to assess strengths and needs and to develop an individualized service plan. The case manager chairs the meetings and is responsible for monitoring the implementation of the plan. The group is reconvened if there are unresolved issues of changes in the child or family's situation. If the creative community options group is unable to resolve difficult and complex barriers to serving the child and family, a referral can be made to the second level of interagency service planning -- the ACCORD (A Creative Community Options Review

Decision). The ACCORD is a standing committee of mid-level managers who represent each of the major child-serving systems. This group of individuals have been empowered by their agencies to make decisions and commit resources to support individualized services for children and families. The Stark County Interagency Cluster has dealt with cases that cannot be resolved at the ACCORD level. This group is made up of executives of the child-serving agencies and has the primary responsibility of system-level planning and coordination. Like Vermont, cases that cannot be resolved at the community level can be resolved at the State Level Interdepartmental Cluster.

✔ The WRAP project in LaGrange Area Department of Special Education, LaGrange, Illinois has utilized three levels of teams. First an Interagency Coordinating Council consists of leaders and decision-makers at the state and local level. This Council is responsible for conducting hands-on system analysis, identifying and designing system improvement, and determining capacity readiness and timelines for changing policies and redirecting existing resources to allow for more flexible use of funds in the development of wrap-around options. A case Coordinating Committee is a subcommittee of the Coordinating Council that focuses on the development of an effective interagency case management system that will result in more positive outcomes for youth and families. This Committee monitors, reviews, and coordinates the targeted cases. The third level of teaming involves the multi-disciplinary team, including the parents, that develops specific wrap-around supports for the child. Instead of planning for the problems, the team looks at the needs of the child/family (e.g., the plan is driven by child/family needs, rather than service availability).

✔ A similar process used in Richland County is referred to as a network meeting. Also organized and chaired by the case manager, the network meeting results in a coordinated services plan with clearly defined roles and responsibilities for all involved agencies and professionals.

✔ The Ohio Department of Health and the Ohio Department of Mental Retardation and Developmental Disabilities have developed a County Collaborative Group Plan Checklist. This checklist is designed to provide guidance and assist the county Collaborative Groups as they develop a comprehensive plan for early intervention services. The checklist incorporates the Eleven Essential Components of an Early Intervention Service System that were approved by the Ohio Interagency Early Intervention Council. These components include: philosophy, child find, interdisciplinary evaluation and assessment, individual family service plan service coordination, follow-along, consumer involvement, family support, training, evaluation, and collaborative comprehensive service system.

✔ A variation on the use of these child-service teams involves the use of one or more multi-agency groups for the purpose of service planning and coordination for

individual children with intensive or complex needs. Northumberland County, Pennsylvania has used its Children's Clinic for this purpose. Within the Children's Clinic, several strategies have been used to enhance interagency collaboration including the Human Services Management Team. The Human Services Management Team is comprised of representatives from each child-serving system who meet on a regular basis to plan, coordinate, and monitor services for youngsters and their families. This group has the power to make policy and program decisions across the agency. A family service plan is developed which presents the goals of intervention, services to be provided, and responsible staff. The family service plan includes a section that identifies methods used to involve parents and a section which requires substantial documentation should an out-of-home placement be used. The need for, appropriateness of, and goals for such placements must be specified along with documentation of efforts to prevent this placement and reunification plans, if appropriate.

- ✔ Norfolk, Virginia created Community Assessment Teams to formulate and coordinate case plans from individual youngsters. Ten such teams have existed in the city, each comprised of supervisory-level workers from the various child-serving agencies. Parents and involved direct service workers have joined the team for discussion of specific youngsters.

- ✔ In Ventura County, California, the Interagency Case Management Council was created to enable interagency planning for especially difficult cases.

- ✔ In the Bluegrass IMPACT (Interagency Mobilization for Progress in Adolescent's and Children's Treatment) program in Lexington, Kentucky a local Child's Interagency Planning and Implementation Team jointly develops a service plan. A Service Coordinator facilitates the implementation of the plan.

- ✔ Sites within South Carolina (Diffusion of Multi-systemic Family Preservation Services project) have utilized family preservation teams to deliver services which are highly flexible, individualized, intensive, and integrated across various systems/agencies.

- ✔ The Parent and Child Cooperative (PACC) project in Delaware County, Pennsylvania has used multi-agency planning teams consisting of representatives from various child serving systems, family members and advocates. A targeted plan identifying specific services and funding sources.

- ✔ A project in North Carolina (Demonstration of Infant Mental Health Services) has used a single entry point and the provision of comprehensive and coordinated services across the involved child service agencies. A community interagency consortium and the infant's family develop a service plan outlining approaches and identifying funding. A service coordinator/case manager implements and coordinates

the plan that may encompass a wide array of services including home-based early intervention, assessment, and family support.

- ✔ Following a five-year federal grant within Vermont, the state passed legislation that codifies a system of care for children and adolescents with severe emotional disturbance. Local interagency teams have been established in the school districts to work together to deliver multi-need services for youth. Local treatment teams develop an individualized service plan.

- ✔ Tennessee has implemented a Children's Plan in 1991 which provides for a major restructuring of its financing and delivery of services to children and families involved with four state departments--education, human services, mental health/mental retardation, and youth development. Assessment and Care Coordination Teams have been established in many of the community health agencies across the state to provide a single point of entry.

- ✔ The Los Angeles School District is part of the Los Angeles County Children's Planning Council that has been formed to co-ordinate and link education, social, and health services in the county service planning areas. Resource Coordinating Councils have been initiated at the school complex level and a Resource Coordinating Team at the school site level to link together multiple services for children/youth and families. The Complex Resource Coordinating Council brings together representatives of each school's Resource Coordinating Team (e.g., counselors, psychologists, nurses, social workers, teachers, attendance and dropout workers, after school playground supervisors, health educators, and parent educators). The role of the Resources Coordinating Team at the school site level is intended to expand to focus on coordinated service planning for individual students, as well as to advocate for broader programming needed to meet local school and community needs.

- ✔ In order to enhance the efficiency of the interagency service planning process, some communities have developed specific formats or time frames to guide the activities of the interagency team. In Leon County Florida, approximately 20 minutes are devoted to presentations from the primary caseworker, staff, and family. Forty minutes are then used for identifying key issues and developing an individualized interagency plan. Creative Community Options teams in Stark County, Ohio outline the history, prepare a people map, identify strengths and problems, what works, what doesn't work, what the child needs, and options to meet needs. Specific formats and time frames can prevent interagency serving planning meetings from becoming lengthy and less productive.

- ✔ Within the State of North Carolina, the Pen-Pal Project has developed an Individualized Service Team (IST) Protocol which includes a facilitator's check list, fax notice, IST Meeting Outline, IST Child Profile, Child and Adolescent Profile

Coding Guide, Interagency Service Plan, Pen-Pal system of Services, a Community Services Menu, and High Risk Intervention Treatment Plan.

- ✔ State policies and implementation procedures have been developed for coordinated, individualized service planning for students with disabilities across special education, mental health, and other agencies as a part of the Felix Consent Decree In Hawaii.

- ✔ Eight steps have been identified for the school-based coordinated services planning process that were adapted from training material developed by the La Grange Area Department of Special Education in Illinois. A description of this eight-step process is found in Appendix B.

Expand parent/family involvement - Coordinated services planning must involve and support parents and families. Parents/families must be viewed as not only the focus of child-serving agencies, but also as partners. The child's family is the most important influence on the child. Therefore, to achieve better outcomes, parents should be actively involved, and their needs considered in the development of coordinated services. The Individuals With Disabilities Education Act (IDEA) Amendments of 1997 have increased the involvement of parents in the educational planning process (e.g., they are to be involved in all phases including assessment, determination of eligibility, IEP planning, IEP implementation, and IEP evaluation/revision). This involvement should be integral to the coordinated services planning process.

Stroul, Laurie, Golden, & Katz-Leavy (1992) reported that, in addition to having service components that are family focused, all of the communities they studied involved parents in the process of developing individualized service plans, (e.g., working in partnership with case managers and/or participating fully on the interagency services planning teams organized for this purpose). Families are considered essential participants in the various types of service planning meetings. Involvement of the families has resulted in increased family investment and commitment to the intervention process. Steps are taken in some communities to help parents feel comfortable with the team process.. Parent volunteers who have previously been through the process are used to brief the family in advance, case managers orient parents before the meetings, and written materials or videotapes are used for orientation and training purposes.

- ✔ In Stark County, Ohio, parents serve on boards and planning committees, participate in a strategic planning process, and have input into the design and development of any new programs. Additionally, support is provided for parents to attend statewide and national meetings.

- ✔ Hawaii has established a statewide network of Children's Community Councils so that parents and community members can be active players in the planning of coordinated services within a seamless system of care.

- ✔ Several Florida communities have implemented strategies to make the parents more at ease with the interagency team process. A parent volunteer, for example, contacts

the parents in advance of a scheduled meeting to explain what will occur, what is expected of them, and to answer any questions the parent have.

Implement interagency case management/care coordination - Systematic case management or care coordination is necessary to assure child and family access to the array of services. Case management or care coordination can assure that access is not limited to initial services, but will also include follow-up and ongoing assessment of progress/lack of progress. Interagency case management can help families benefit from available services. Effective case management can also provide key information on how well existing services meet family needs and highlights the areas needing change. Interagency case management can use an individual hired or designated by participating agencies, an existing staff person re-deployed from a partner agency, or a team of specialists from a variety of agencies that is given the authority to perfonn several functions.

A parent, a teacher, or another agency staff member can serve as a case manager or care coordinator for their child. Case management or care coordination activities can include assessing needs and planning services jointly with families, connecting families to multiple agencies, monitoring their progress, and advocating for more effective service delivery in all of the agencies that provide services to children and families. The primary functions of a case manager or care coordinator is to advocate, coordinate, educate, facilitate, and encourage creativity.

- ✔ The purpose of a case manager, as stated in *Vermont's Plan for Statewide Implementation of Therapeutic Case Management* (1990), is to use natural supports in the community and/or organize services provided by agencies. Therapeutic case mangers act as the person accountable for coordinating and ensuring appropriate and timely services for the child/adolescent and his/her family. They are responsible for brokering services for individuals and advocating on the child's behalf across service systems. Therapeutic case managers ensure that adequate treatment plans are developed and implemented, and provide ongoing review of the child's progress and program outcomes. Vermont's therapeutic case managers carry out the following assessment, planning, linking, monitoring, and evaluation roles:

  - ✱ Assure that there is 24-hour crisis coverage;
  - ✱ Provide supervision and support to the residential provider;
  - ✱ Chair team meetings, record and disseminate minutes;
  - ✱ Maintain contact with team members to share information, problem solve, and provide support;
  - ✱ Arrange for services needed, including consultation with experts;
  - ✱ Keep track of expenditures and be responsible for the "flex dollar" account
  - ✱ Maintain contact with the Department of Mental Health; and
  - ✱ Be available for planning and brokering of services in times of crisis.

- ✔ Within the Family Service Planning Team (FSPT) structure throughout Florida counties, a designated case manager is appointed during the staffing by the FSPT

chairperson. The case manager most frequently is the referring agent conjointly with the parent/caretaker. The FSPT case manager is responsible for coordination and monitoring of the Family Service Plan and for presenting reviews of the plan to the FSPT on a regular basis.

✔ In Hawaii, a care coordinator is responsible for initiating the Coordinated Service Plan process, scheduling the first meeting, facilitating implementation of the Coordinated Service Plan, assisting the parent with ongoing communication with the school and other service providers, and advocating for the child on an ongoing basis.

Allow time for reflection and celebration - An essential component in the overall evaluation/accountability effort should be time for reflection and celebration through formal conferences and/or informal events/activities across programs within the schools and across the schools and other agencies. Opportunities for reflection will help focus on those aspects that are working well as well as those areas that need finetuning and change. Celebration and reflection can also strengthen the ongoing commitment to working in a coordinated and integrated manner.

Individualized Plan Development

Utilize a coordinated services plan format that incorporates the IEP and IFSP for younger children, or that is linked and coordinated with the IEP or IFSP. A number of states and communities have developed specific approaches and formats to an interagency coordinated services plan that assists in efficiency and communication across the interagency service team players, including parents. In some cases, the mental health plan, the school's individualized education plan (IEP), and other agency service plans are kept separate--and are then coordinated. Or, the individual agency service plans may be kept separate and another more comprehensive service plan developed. Appendix C includes examples of some of these plans/formats. Regardless which approach is used, the coordinated services plan should be needs driven rather than service driven, based on the unique educational and related service needs of the student as well as needs identified by the family. It should be strengths-based, be focused on normalization, include services to be provided which are culturally competent, and have outcome measures that are periodically measured.

✔ Treatment Teams in Vermont work together with the leadership of the therapeutic case manager to design an individualized care plan that meets the child's and family's needs and addresses their strengths (See Appendix C for a copy of the coordinated services plan format). The following considerations are kept in mind when designing individualized care plans:

- Considerations are made for child/family preferences.
- Provisions are made for how a crisis will be handled.
- Provisions are included for helping the child and caregivers to feel safe.
- The coordinated service plan utilizes the child and family's natural support system and community services.
- The planning process is clear and concrete.

- Respite for the child and residential caretakers is planned.
- Flexible, dynamic treatment plans are utilized.
- More security is provided during the initial months on the individualized care program, with the restrictiveness eased as the child demonstrates an ability to function without serious incident.

✔ In developing individual plans for students with disabilities, Youth Service Teams in Oregon have a menu of areas to consider (e.g., family strengths, critical needs, current family resources, and resources needed/wanted).

✔ Within the Cordero Consent Decree in Pennsylvania, guidelines have been established through the Interagency Support Project to coordinate individualized education plans (IEP) and individualized service plans (ISP) for class members. These Guidelines (Resource Guide for IEP Teams) include a framework/format for IEPs and ISPs which is consistent with existing requirements for each plan. Also included is a description of the development process for IEPs and ISPs covering roles and responsibilities of families and professionals, the mechanisms and procedures for receiving technical assistance, and training in the development of coordinated IEPs and ISPs.

✔ As a part of the Willie M Consent Decree within North Carolina planning teams have developed treatment/habilitation plans which incorporate the IEP and the mental health Individual Treatment Plan (ITP). A copy of this document is found in Appendix C.

✔ The State of Maine has developed policies and procedures for coordinating their Individual Education Plan and the Individual Service Plan. The Individual Education Plan is developed by a Pupil Evaluation Team (PET) and contains, at a minimum, a description of the following: a section identifying the client's exceptionality and a description of the present level of and constrains on the client's performance; necessary special education and supportive services (and amount and staff responsible for provision of such services); dates of initiation and duration of special education and supportive services; annual educational goals and short term instructional objectives; a summary of any necessary special education transportation; and a schedule to measure progress toward a client's goals. The Individual Service Plan specifies the service components to be provided, the frequency and duration of each service component and the expected short and long range treatment and/or rehabilitative goals or outcome of services.

✔ In Illinois, Individual Wraparound Plans are developed for students with disabilities requiring services from more than one agency. The wraparound process results in the identification and delivery of comprehensive, coordinated services based on strengths and addresses needs across all life domains (e.g, family, place to live, education, social/recreational, emotional/psychological, vocational, safety, medical,

legal, and spiritual). The wraparound approach blends traditional and non-traditional resources, and frequently results in the creation of new services that meet the unique and changing needs of each child.

✔ The PEN-PAL project in North Carolina has developed a standardized Family and Interagency Service Plan (found in Appendix C). This Family and Interagency service Plan includes services needed for a crisis plan, a community services menu, wraparound services menu, and a high risk intervention treatment plan which includes the IEP componerts.

✔ In Minnesota, a Collaborative Family Service Plan has been developed that qualifies as a substitute for the IEP required for all students with disabilities. This Plan is utilized by appropriate state agencies, including the Department of Education and the Department of Children, Families & Learning. The Collaborative Family Service Plan can also serve as the Individualized Family Service Plan (IFSP) for children ages birth to three. This Collaborative Family Service Plan also fulfills the requirements of Section 504 of the Vocational Rehabilitation Act of 1973. The Collaborative Family Service Plan also can serve as an Individual Treatment Plan required for medical assistance payment, and an Individualized Family Community Support Plan required for medical assistance reimbursement of case management services. The Collaborative Family Service Plan is intended to guide the process in which families and other team members work together in an integrated and coordinated approach to service delivery. The Plan outlines: measurable client outcomes and specific objectives and services needed to attain these desired outcomes; agencies or persons responsible for providing and paying for these Services; timelines; judicial or administrative procedures needed to implement the plan; and the person responsible for overseeing implantation. A copy of this plan that is being piloted within selected sites is provided in Appendix C.

The Minnesota Collaborative Family Service Plan assures that procedural safeguards are implemented throughout the system including parental informed consent, notification and authorization, confidentiality and privacy rights, appeals, and due process.

✓ Within the coordinated services planning policy of the State of Hawaii, school districts/community agencies have the option of utilizing a single format for the IEP and the mental health ITP or using separate formats and coordinating their development and implementation. An example of a separate individual family care plan/individual service plan are included within Appendix C.

✔ Within Florida, a standardized service plan is used to ensure that service delivery and system accountability are consistent across districts in the state. The Family Service Plan is linked with the IEP and the mental health Individualized Treatment Plan.

- ✔ *Connections* within the State of Ohio is a cooperative effort between the Positive Education Program (PEP) and child-serving systems throughout Cuyahoga County. Connections places full-time mental health professionals into the public schools and throughout the community to work with students experiencing serious emotional difficulties. The Connections Intake Team meets twice a month to develop and monitor the implementation of Individualized Service Plans for these students. A case manager is assigned to each child referred and involves representatives from the child's entire ecology when developing an individualized service plan that is specifically designed to address is/her full spectrum of needs. This plan includes the requirements of the IEP. A copy of this plan is found in Appendix C.

- ✔ The Independent, Missouri School District and other health and human service agencies have also implemented coordinated services planning. A copy of the coordinates services plan being used in found in Appendix C.

SUMMARY

Many school districts and community agencies are engaging in coordinated services planning for children and youth with disabilities and their families, including approaches that are client-centered, program centered, policy-centered, or organizationally-centered. Planning holistically for children and their families is reinforced by the IDEA Amendments of 1997, in which Congress encourages state and local agencies to work collaboratively with other agencies and parents. This document discusses a number of policy and implementation issues to be considered when developing and implementing coordinated service planning across education and other human services using program-centered and client-centered inter-disciplinary teaming approaches.

The first coordinated services planning policy and implementation consideration involves vision and leadership. There must be a commitment to a shared vision that includes common goals and directions. Leadership is also important that promotes action, collaboration, and respect for student and family diversity.

Within the authority and responsibility policy area, a governance structure needs to be identified that designates the locus of responsibilities. Roles and responsibilities will change when planning holistically for children and youth with disabilities. Case managers, for example, will be advocates for children and youth and their families to ensure that services planned and committed to are, in fact, carried out and that they are evaluated for effectiveness and positive impact. School and other agency personnel will need to be flexible and creative in working across job roles and across agencies. Newly-defined roles and responsibilities can be detailed in formal or informal interagency agreements or working procedures. An important strategy that has been determined important across the country for effective coordinated services planning is increasing authority on the front line and allowing schools and community agencies additional policy and fund flexibility for determining timely and creative services and supports for children and youth.

Once the scope of interagency co-ordinated services planning has been identified, it is recommended that there be a single point of entry across agencies involved, as well as interagency screening, identification, and evaluation procedures. Definitions and eligibility criteria will need to be aligned across agencies. In carrying out interagency evaluation and assessment of children and youth, it is important to utilize strengths-based assessment rather than the traditional child deficit approach. In carrying out interagency coordinated services planning for children and youth, staff supervision will need to continually encourage collaborative planning and service delivery. There may be credentialing or licensing issues to remedy. Likewise job descriptions across roles may also need to be revised.

New forms of accountability will need to begin with a common set of program and student/family outcomes. This document suggests a number of child status, service system performance, educational status, and social status indicators to be considered.

Fiscal strategies to support interagency coordinated services planning must be family-oriented, comprehensive, flexible, prevention oriented, and outcome-based. Innovative fiscal strategies can include re-direction or re-deployment of funds, cost sharing/blending of funds, maximizing third party resources, flexible funding approaches, leveraging of funds, maximization of federal funds, and de-categorizing of funds to allow broader uses.

Another set of policy considerations inherent within interagency coordinated services planning includes management of student information. For example, procedures will need to be implemented to share and maintain student information in a confidential manner by school and other agency personnel working with children and youth. An interagency management information system can help to manage student information and assure confidentiality and privacy for children and families.

This document provides considerable descriptions of various teaming structures that are being utilized across the country. A wide range of terms have been given for these teams including individualized support team, community support team, creative community options team, coordinated services planning team, state interagency team, etc. This document also emphasizes the need to involve parents as integral members of the coordinated services planning team.

When documenting the interagency plans developed for children and youth with disabilities, some states and community agencies are using an umbrella co-ordinated services plan that includes and meets the requirements of the IEP, IFSP, mental health treatment plan, and other agency service plans. Other states and community agencies are continuing to develop separate IEP and other agency plans, but they are using strategies for linking plans such as through the use of inserts to a separate coordinated service plan. Examples of coordinated services planning formats have been appended to this document for review.

REFERENCES

Academy of Pediatrics (1994). *Integrating education, health and human services: Principles to link by.* Washington, DC: Author.

Ahearn, E. (1997). School-linked services in K-12 systems: An annotated resource list. Washington, DC: Project FORUM, National Association of State Directors of Special Education.

American Psychological Association (1995). *Comprehensive and coordinated psychological services for children: A call for service integration.* Washington, DC: Author.

Bruner, C. (1991). *Thinking collaboratively: Ten questions and answers to help policy makers improve children's Services.* Washington, DC: Education and Human Services Consortium, 1991. p. 6.

Buchard, J.D., & Clark, R.T. (1990). *The role of individualized care in a service delivery system for children and adolescents with severely maladjusted behavior.* The Journal of Mental Health Administration, 17, 48-60.

Center for Mental Health in Schools (1996). *Confidentiality and informed consent.* University of California at Los Angeles, Los Angeles, California.

Center for Mental Health in Schools (1996). *Evaluation and accountability: Getting credit for all you do.* Department of Psychology, University of California at Los Angeles, Los Angeles, California.

Center for Research for Effective Schooling for Disadvantaged Students (July, 1992). *Integrate services to remove barriers.* Baltimore: Johns Hopkins University, p. 11.

Center for the Future of Children (1992). *The Future of Children.* 2(1). Los Altos, CA: The David and Lucile Packard Foundation.

Coulton, C.J. (1992). *Framework for evaluating family centers.* Cleveland, OH: Center for Urban Poverty and Social Change, Case Western Reserve University.

Council of Chief State School Officers (1992). *Ensuring student success through collaboration: Summer institute papers and recommendations of the Council of Chief State School Officers.* Washington, DC: Author

Cutler, I. (1994). *The role of finance reform in comprehensive service initiatives.* Washington, DC: The Finance Project.

Dolan, L.J. (1992, March). *Models for integrating human services into the school. CDS Report No. 30.* Baltimore: The Johns Hopkins University.

Dryfoos, J. (1994). *Full-service schools*. San Francisco: Joseey-Bass.

Farrow, F. & Joe, T. (1992) *Financing school-linked, integrated services*. In: *The Future of Children School Linked Services 2*(1), 56-67.

First, P.F., Curcio, J.L., & Young, D.L. (1994). *State full-service school initiatives: New notions of policy development*. In L. Adler & S. Gardner (Eds.) *The politics of linking schools and social Services*. Washington, D.C.: The Falmer Press, pp 63-72.

Gardner, H. G., & Orelove, F.P. (1994). *Teamwork in human services: Models and applications across the life span*. Boston, MA: Butterworth-Heinemann.

Garvn, J.R., & Young, A.H. (1993). *Resource issues: A case study from New Orleans*. In L. Adler & S. Gardner (Eds.). *The politics of linking schools and social services* (pp. 93-106). London: the Falmer Press.

Greenberg, M., Levy, J., & Polaick, R. (1992). *Confidentiality and collaboration: Information sharing in interagency efforts*. Denver, CO.: Education Commission of the States.

Hooper-Briar, K., & Lawson, H. (1994). *Serving children, youth & families through interprofessional collaboration and services integration*: A framework for action. Oxford, OH: The Institute for Educational Renewal, Miami University.

Hutcheson, S. (1996). *A vision for children's information systems*. TA Brief 2(1), 3-7.

James, W.H., Smith, A., & Mann, R. (191). *Educating homeless children: Interprofessional case management. Childhood Education*, 67(5), 305-308.

Jehl , J. and Kirst, M. *Getting ready to provide school-linked Services: What schools must do.* In: *The Future of Children School Linked Services* 2(1), pp. 95-106.

Kagan, S.L., Goffin, S.G., Golub, S.A. & Pritchard, E. (1995). *Toward systemic reform: Service integration for young children and their families.* Falls Church, VA: National Center for Service Integration.

Kahne, J. & Kelley, C. (1993). *Assessing the coordination of children's Services: Dilemmas facing program administrators, evaluators, and policy analysts*. Education and Urban Society, 25(2), 187-200.

Kinney, J., Strand, K., Hagerup, M., & Bruner, C. (1994*). Beyond the buzzwords: Key principles in effective frontline practice.* Falls Church, VA: National Center for Service Integration.

Kirst, M. (1994, September). *School-linked services: An appraisal and future direction.* Paper presented at the Invitational Working Conference on Comprehensive School-linked Services for Children and Families, Leesburg, VA.

Kirst, M. W. (1991) *Improving children's services. Phi Delta Kappan 72*(8), 615-618.

Kirst, M.W. (1993). *Financing school-linked services. Education and Urban Society, 25*(2), 166-174.

Knapp, M.S. (1995). *How shall we study comprehensive collaborative services for children and families. Educational Researcher, 14(*4), pp. 5-16.

Koppich, J.E. (1993). "The politics of policy making for children." In L. Adler & S. Gardner (eds.), *The politics of linking schools and social Services.* Washington, D.C.: The Falmer Press, pp 51-62

Kraus, A. & J.B. Pillsbury. (1993). *Making it simpler: Streamlining intake and eligibility systems.* Columbia University, New York: National Center for Service Integration.

Levy, J.E., and Copple, C. *Joining Forces, A report from the first year.* Alexandria, VA: National Association of State Boards of Education, 1989.

Levy and Shepardson (1992) *A look at current school-linked service effort.* In: *The Future of Children School Linked Services* 2(1). 44-54.

Linn-Benton-Lincoln Education Service District (1996). *Linn county youth service teams: An interagency collaboration approach to providing services to youth and their families.* Author: Albany, OR.

Liontos, L.B. (1991). *Social services and schools: Building collaboration that works.* Oregon School Study Council, 35(3). 44-42.

Los Angeles Unified School District (1998). *Grant Proposal: Elementary and Secondary Education Act - Title XI - Coordinated Services Projects.* Los Angeles Unified School District: Author.

MacFarquhar, K.W. & Dowrick, P.W. (1992) *Individualizing services for seriously emotionally disturbed youth: A nationwide survey. Administration and Policy in Mental Health.*

Maine State Department of Education (1996). *Maine medical assistance manual.* Augusta, MA: Author.

Markowitz, Jan (1998). *Training handouts - Coordinated services planning.* Honolulu, HI: Felix Monitoring Office.

Marzke, C.H., Chimerine, C.B., Morrill, W.A., & Marks, e.g. (1992). *Service integration programs in community settings*. Falls Church, VA: Mathtec, Inc.

Mclaughlin, M.J., Leone, P.E., Warren, S.H., & Schofield, P.F. (1994). *Doing things differently: Issues & Options*. College Park, MD: University of Maryland at College Park and WESTAT Inc.

Melaville, A., & Blank, M.J. With G. Assayesh (1993). *Together we can: A guide for crafting a profamily system of education and human Services*. Washington, D.C.: U. S. Department of Education and U.S. Department of Health and Human Services.

Melaville, A. & Blank, M.J. (1991). *What it takes: Structuring interagency partnerships to connect children and families with comprehensive Services*. Washington, D.C.: Education and Human Services Consortium.

National Association of State Boards of Education. (1997). *Coordinated services for all children and youth. Issues in Brief*, pp. 1-16.

Olson, D.G., Whitbeck, J, & Robinson, R. (1991). *The Washington experience: Research on community efforts to provide individualized tailored care*. Presented at "A System of Care for Children's Mental Health: Expanding the Research Base," Tampa, Florida.

Pittman, K. J. & Cahill, M. (1992). *Pushing the boundaries of education: The implications of a youth development approach to education policies, structure, and collaborations*. In: Council of Chief State School Officers. *Ensuring student success through collaboration: Summer institute papers and recommendations of the council of chief state school officers*. Washington, DC: Council of Chief State School Officers.

Pollard, J.S. (1990, May). *School-linked Services--So that schools can educate and children can learn. Part l. Insights on Educational Policy and Practice. No. 20*, pp 1-4.

Robinson, E. (1993). *An interim evaluation report concerning a collaboration between the Children's Aid Society and the New York City Board of Education Community School District 6 and the I.S.218 Salone Urena de Henriquez School*. New York: The Children's Aid Society.

Robinson, S. (1990). *Putting the pieces together: survey of state systems for children in crisis. Denver*, CO: National Conference of State Legislatures.

Schrag, J., Groves, I., & Foster, R. (1998). *Interagency collaborative team evaluation*. Tallahassee, FL: Human Systems and Outcomes, Inc.

Shaw, K.M., & Replogle, E. (1995). *Challenges in Evaluating School-Linked Services: Toward a more comprehensive evaluation framework*. Cambridge, MA: Harvard Family Research Project.

Soler, M.I. (1993). *Who should know what? Confidentiality and information sharing in service integration*. Resource Brief 3. New York, N.Y.: National Center for Service Integration., Columbia University.

Stroul, B.A. & Friedman, R.M. (1986). *A system of care for children youth with severe emotional disturbances*. Washington, D.C.: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

Stroul, B.A., Lourie, I.S., Goldman, S.K., & Katz-Leavy, J.W. (1992). *Profiles of local systems of care for children and adolescents with severe emotional disturbances*. Georgetown, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

Sullivan, C. & Sugarman, C. (1995). *Interagency data systems for accountability.* Washington, D.C. Council of Chief State School Officers.

U.S. Department of Education ((1996). *Putting the pieces together: Comprehensive school-linked strategies for children and families*. Washington, D.C.: Author.

United States General Accounting Office (1998). *Flexibility initiatives do not address districts' key concerns about federal requirements*. Washington, DC: Author.

VanDenBerg, J. (1989). *Alaska youth initiative: Program background*. Juneau, AK. Alaska Department of Health and Social Services, Division of Mental Health and Developmental Disabilities.

VanDenBerg, J. (1991). *Alaska youth initiative*. Juneau, AK: Alaska Department of Health and Social Services, Division of Mental Health and Developmental Disabilities.

VanDenBerg, J.(1992). *Integration of individualized services into the system of care for children and adolescents with emotional disabilities*. In: Katz-Leavy, ;J.W., Lourie, I.S., Stroul, B.A., & Zeigler-Dendy, C. (1992). *Individualized services in a system of care*. Washington, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

VanDenBerg, J. (1993). *Integration of individualized mental health services into the system of care for children and adolescents. Administration and Policy in Mental Health 20*(4), pp. 247-257.

Wilson, W., Karasoff, P., & Nolan, B. (1993). *The integrated services specialist: An interdisciplinary preservice training model.* In L. Adler 7 S. Gardner (Eds.), *The politics of linking schools and social services* (pp. 161-164). London: the Falmer Press.

Vermont's Plan for Statewide Implementation of Therapeutic Case Management (1990).

Young, N., Gardner, S., Coley, S., Schorr, L., & Bruner, C. (1994). *Making a difference: Moving to outcome-based accountability for comprehensive service reforms*. Falls Church, VA: National Center for Service Integration.

APPENDIX A

Hawaii State Policy - Coordinated Services

FELIX IMPLEMENTATION PLAN

POLICY ON COORDINATED SERVICE PLANNING FOR CHILDREN/YOUTH

Coordinated service planning (CSP) will be provided in the state of Hawaii for all children/youth in the state who are in need of special education, mental health and/or related services from two or more agencies and/or providers and all children who are currently being served by two or more agencies and/or providers. CSP is for those children/youth in need of services of a scope and intensity beyond the capacity of any one agency to provide, ie: children/youth in need of: a significant number of mental health services, protective supervision or foster care, or involvement of the Family Court.

CSP is a process in which families and other team members work together in an integrated and collaborative approach to service delivery. CSP is based on the premise that the children/youth receiving multi-agency services, their families, the community, and all agencies involved in providing those services actively participate in the development of the integrated service plan. The service plan will be received and revised by all participants on a regular basis.

The service plan will be family-centered and strengths-based and include long-term view transition program planning, educational services and programs, clinical/therapeutic services, and least restrictive environment considerations. The service plan will identify a single care coordinator and will also detail: 1) measurable child/youth and family outcomes and specific services needed to attain those desired outcomes; 2) necessary services; 3) procedural timelines; 4) judicial or administrative procedures needed to implement the plan; and 5) the person responsible for overseeing implementation of the entire plan and its specific components. In both service planning and delivery, procedural safeguards shall be adhered to throughout the system. Procedural safeguards will address parental and/or child/youth (where appropriate) informed consent, appropriate notification to address the needs of the child/youth and family and authorization, confidentiality and privacy rights concerning some or all information regarding the child/youth and family, and appeals and due process.

NOTE: The Individualized Education Program (IEP) is an educational component of, not the totality of, the coordinated service plan.

PROCEDURES ON
COORDINATED SERVICE PLANNING FOR CHILDREN/YOUTH

CSP is a process of bringing together the family, multiple agencies and providers, and the child/youth, when appropriate, to develop a comprehensive and integrated plan of individualized care for the child/youth that is based on the child's/youth's strengths and needs in all life domains. CSP:

1) will follow the Child and Adolescent Service System Program (CASSP) principles;
2) identifies service needs and remedies service gaps;
3) facilitates the appropriate use of resources;
4) minimizes duplication of services; and
5) provides the ability to track individual child/youth and family outcomes.

To achieve these objectives, CSP must promote collaboration of all agencies, providers and family members involved in the care of the child/youth, when appropriate the child/youth should be involved in the planning process. These individuals and agencies, when working together on a service plan for a child/youth, comprise the CSP team.

CSP is for those children/youth requiring educational modification (either IDEA or Section 504 services) and/or mental health services. However, it is also designed and may be used as needed for any child/youth being served by two or more agencies and/or providers.

When To Use Coordinated Service Planning

A child/youth needs CSP when a family member, service provider or care coordinator:

1) determines that the child/youth needs the services of two or more agencies and/or providers (see "Procedures for Identifying and Determining Eligibility for Educational and/or Related Services," adopted jointly by the Departments of Education and Health), or
2) determines that the child/youth is currently being served by two or more agencies and/or providers.

A child/youth can be referred by the care coordinator for any service plan, for example, IEP, Individual Family Support Plan (IFSP), Modification Plan (MP), including a member of the school's Student Support Team(SST), a parent, a service provider, or a care coordinator.

Indications of the need for CSP may include:

- the child's/youth's need for services of a scope and intensity beyond the capacity of the school to provide through the SST and/or the Section 504 Modification Plan/IDEA Individualized Education Program (IEP) process alone;
- a significant number of mental health services being provided to the child/youth;
- Provision of protective supervision or foster care provided to the child/youth by the Department of Human Services;
- Family Court involvement with the child/youth;
- significant problems the child/youth is having at home which impact school performance.

Responsibilities of the Care Coordinator

The individual who serves as the single agency care coordinator for the child/youth will need to prepare for the initial CSP meeting by completing the following tasks:

1) contact parents or legal guardians within three (3) working days of request
2) discuss the CSP process with the family and child/youth and secure the necessary consents;
3) identify an appropriate time and place for the CSP meeting to occur;
4) notify all relevant parties/participants that a planning meeting will be held (including people of the parents' choosing);
5) collect all previously-completed individual treatment and service plans for the child/youth and distribute copies of these documents to the CSP team before the first meeting; and
6) identify the most suitable person on the CSP team to develop the agenda and run the planning meeting. If the care coordinator is unable to identify such an individual, the single agency care coordinator assumes responsibility for those tasks.

The Coordinated Service Planning Meeting

The care coordinator for a child/youth is the person responsible for initiating the CSP process and scheduling the first meeting. The CSP meeting must be held within thirty (30) calendar days of receipt of the initial request for such a meeting. Any IEP, IFSP, MP, individual treatment plan and all other service plans developed for a child/youth will be incorporated into or coordinated with the coordinated service plan for that child/youth.

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Responsibilities of the Coordinated Service Planning Team

The CSP team consists of representatives of all agencies and providers serving a child/youth, family members of the child/youth, and individuals chosen by the family to be included.

Members of the CSP team will work collaboratively to:

1) identify all the parties/participants necessary to complete the CSP;
2) allow for an open exchange of information among all team members;
3) identify existing assessments of the child/youth and determine how they might be accessed and applied;
4) determine child/youth and family strengths and needs;
5) develop short term, intermediate and long term goal that would allow the child/youth to remain in his/her current environment or that would immediately resolve a crisis;
6) develop strength-based specific, measurable and observable objectives and strategies to assist the child/youth in achieving the defined goals;
7) develop a crisis response plan for the child/youth, when appropriate;
8) assign team members as the responsible party for each of the goals, objectives and strategies to insure they are accomplished in the specified time;
9) determine specific services/resources/supports for each objective and strategy;
10) determine funding sources for each service/resource/support;
11) determine a date for a review of the plan;
12) establish communication between the child's/youth's family and all agencies and providers to insure effective and efficient monitoring of the child's/youth's progress;
13) obtain plan approval by the signatures of all team members;
14) designate the multi-agency care coordinator for the plan, who is responsible for writing up the CSP, distributing copies of the plan to all team members, overseeing the implementation of the service plan, and communicating with all relevant parties about the plan;
15) establish a timeline for sending copies of additional treatment plans and reports on the child's/youth's progress to the multi-agency care coordinator for the CSP;

The CSP team must complete the development of the plan for a child/youth within forty-five (45) calendar days of the receipt of the initial request for a CSP meeting for that child/youth. Implementation of this plan must begin immediately upon completion of its development. Critical services must be provided, if necessary, during plan development.

Funding of Services Specified in the Coordinated Service Plan

The funding sources for all services specified in a CSP must be identified and agreed to by the CSP team by the end of each planning meeting. Pre-meeting discussions across service providers and the parents can help identify potential services needed and/or resources to be utilized. Any disagreements about the funding source for a particular service will be resolved by the team itself. When funding of a service becomes an unresolved issue for the service planning team, the parents of the child have the option to attend or not attend the meetings of the team to come to funding agreements.

Should the funding source for a service remain an unresolved issue, the CSP team will refer the matter to an appellate board consisting of the District Education Specialist for the school district and the mental health Branch Chief, who will be responsible for resolving the dispute within fifteen (15) days from the time the appellate board receives notice of the dispute. If the dispute cannot be resolved by the appellate board, the board will refer the issue to the Felix Operational Management Team (OMT) for timely resolution. Any dispute over funding will not delay the onset of services for the child/youth as specified in the CSP. If the Department of Education (DOE) is one of the parties to the CSP for a child, DOE will pay for the cost of the services called for in that plan until the dispute can be resolved. If the Department of Health (DOH) is one of the parties to the CSP for a child/youth, but DOE is not a party to that particular plan, then DOH will pay for the cost of the services called for in that plan until the dispute can be resolved.

Review of the Coordinated Service Plan

A review of the CSP will occur at least quarterly but may occur sooner and/or more often than once a quarter, as determined by the CSP team. The parents of the child/youth or any agency or provider giving services to the child/youth, as specified in the service plan, may request a review meeting in addition to the quarterly meeting. This request should be made to the multi-agency care coordinator for the CSP. The multi-agency care coordinator or another person designated by the service planning team will be responsible for convening all review meetings. The review meeting will be held within ten (10) calendar days of receipt of the request.

The purposes of the review meeting are to:

1) review the long-term and short-term goals specified in the CSP and revise the goals, when appropriate;
2) review the objectives and strategies specified in the service plan and their effectiveness in achieving the stated goals and revise the objectives and strategies, when appropriate;
3) review the effectiveness of the services being given and change the services, when appropriate;
4) review the effectiveness of communication between the child's/youth's family and all agencies and providers and restructure the communication, when appropriate;
5) specify any new services needed;
6) approve the revised CSP, as indicated by the signatures of all team members; and
7) access any newly-identified and agreed-upon services.

APPENDIX B

Illinois Coordinated Services Planning Process

Coordinated Services Planning Process

Step 1: Prepare and develop the school team.

Outcomes:

- Students/parents and other stakeholders get heard.
- School-based team members and resource options are identified.
- Unique aspects of building culture are identified.
- The tone is set.
- Expectations of key stakeholders are determined.
- Alliances between school staff and parents are built.
- A sense of hope across all team members begins to be generated.

Step 2: Start the meeting with strengths.

Outcomes:

- Student, family, and teachers are encouraged to bring their assets to the process.
- Group sees individual as having strengths rather than just problems.
- Individual teachers begin to build public investment in outcomes.
- A blame-free environment is required.
- Alliance begins to be built between parent and teacher.

Step 3: Sets the stage for outcomes and consensus building across all team members for academic and social goal setting.

Outcomes:

- All team members have input into process are assured.
- Goals/dreams are agreed upon for the group.
- Key stakeholders are encouraged to voice concerns within the school day.
- Relationship between parent and teacher is strengthened.
- Definitions of success across all team members are operationalized.
- Cultural legitimacy is assured.
- Group learns to talk with jargon-free language.

Step 4: Identify needs specific to the student.

Outcomes:

- Student/family is provided with the opportunity to voice their own needs.
- Teachers input is considered in developing academic options and classroom supports.
- Culture, background, and situational aspects of the student and his/her family is validated.
- Direction is provided to the team related to service creation and academic adjustments.
- The team is encouraged to consider simple solutions.

Step 5: Vote and prioritize.

Outcomes:

- Team agreement and builds focus is assured.
- A sense of accomplishment for team members is built.
- Follow-up tasks become manageable.

Step 6: Carry out action planning.

Outcomes:

- Teacher investment is assured by providing them with the opportunity to create interventions.
- Parent/student ownership is supported by asking where efforts should be targeted.
- The team is empowered to consider service creation.
- Group buy-in and recognition of the possibilities is assured
- Consumer voice by identifying their own needs is assured.

Step 7: Establishment commitment and identify follow-up.

Outcomes:

- Ownership of specific tasks by team members is encouraged and supported.
- Expectations for unconditional care is given.
- A sense of team is developed.
- Team identifies how it will function.
- Consumer ownership is assured.

Step 8: Carry out process evaluation.

Outcomes:

- Team members are expected to own process.
- Team members are encouraged to voice concerns.
- Team members are re-acquainted with values.
- Facilitators are required to adjust process to meet individual needs. of family and school staff.

APPENDIX C

Coordinated Services Plan Formats[1]

[1] The use of these forms are not necessarily required to be compliant with IDEA.

Coordinated Service Plan Form

"A Coordinated Service Plan is a written addendum to each service plan developed by an individual agency for a child or adolescent with severe emotional disturbances which shall be developed when the eligible child has needs that require services from more than one agency. It shall be designed to meet the needs of the child within his or her family or in an out-of-home placement, and in the school and the community." [Act 264, revised, 1989]

A. Background

1. This Plan has been developed for _____ __/__/__

2. This youth has been determined to be eligible for a coordinated service plan on ___/___/___ This plan will be developed by ___/___/___ (within 60 days of eligibility determination).

3. Plan developed with:	Yes	No	N/A	4. Copy sent on date below
Parents	☐	☐	☐	___/___/___
Guardian	☐	☐	☐	___/___/___
Ed. Surrogate Parent	☐	☐	☐	___/___/___
Participating Agencies	☐	☐	☐	___/___/___
Private Providers	☐	☐	☐	___/___/___
Child's attorney	☐	☐	☐	___/___/___

B. Service Needs of the child/adolescent:

C. Service Currently Provided	Agency Providing	How Funded

D. Unmet Service Needs	Why Service is Not Being Provided

E. Case Management Responsibility

1. Primary case manager: _____ _____ _____
   Title Agency

2. Secondary case manager (if applicable) _____ _____ _____
   Title Agency

F. Reintegration Plan

(Required if out-of-home or out-of-school placement is made or recommended.)

Steps to Accomplish	Supporting Services	Anticipated Timeframe

G. Right to Confidentiality

The child and family applying for a coordinated service plan has the right to confidentiality. Case information relevant to the assessment for eligibility or development and implementation of a coordinated service plan will be shared only with the child's treatment team members and relevant service providers. Penalties for improper disclosure of confidential information are listed in Title 18, V.S.A. Chapter 171, Section 7103.

H. Signatures of All Participants

Name	Relationship to Child/Adolescent
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I. Plan to be Reviewed _____
(1 year anniversary)

Review or Revision of Coordinated Service Plan

_____ _____
Name of youth Date of birth

A. Background

1. This plan is [check one of the following]:
   - ☐ due for annual review
   - ☐ being revised at the request of _____, _____
     Name Relationship
   - ☐ is being considered by _____
     Agency
     for a significant change in: ☐ the plan
     ☐ the placement
2. The case manager, _____, is responsible for arranging the review in coordination with the treatment team and for notifying all the participants of the results.

B. Timeframes

___/___/___ date review is scheduled/requested

___/___/___ date of decision as to revision (within 30 days of request for revision or within 30 days of request for significant change)

C. Changes

1. ☐ No significant changes needed at this time.
2. ☐ Additional service needs:

Additional Service(s)	Agency Providing	How Funded

3. ☐ Deletion of services:

Services Being Terminated	Reason for Termination

4. ☐ Change in placement:

Current Placement	Proposed Placement	Reason for Change

D. Unmet Service Needs

Unmet Service Needs	Why Services Are Not Provided

E. Signatures of all Participants

Name	Relationship to Child/Adolescent	Date Copy Sent
_____	_____	__/__/__
_____	_____	__/__/__
_____	_____	__/__/__
_____	_____	__/__/__
_____	_____	__/__/__
_____	_____	__/__/__
_____	_____	__/__/__

F. Date of Next Anticipated Review: _____.

DMH 10/95

NORTH CAROLINA
WILLIE M.

Plan Approval Date: _____

TREATMENT / HABILITATION PLAN

Area Program: _____ Case Manager: _____

Host Area Program: _____ Day Provider Contact: _____

Name: _____ Unique Client ID: _____
(As it appears on Medicaid Card)

Address: _____ Phone: _____
(Street, Box, Number, Route)

_____ SSN: _____
(City, State, Zip) (County)

Medicaid No.: _____ Medicare No.: _____

DOB: _____ Sex: F M (Circle response) Race/ Ethnicity: W AA H NA A Other: _____ (Circle response)

CONTACT PERSON (Check One)

☐ Responsible Person ☐ Guardian

Type of Guardianship: _____

Date of Adjudication: _____

Name: _____
(Last) (First) (MI)

Address: _____ Phone: (H) _____
(Street, Box, Number, Route)

_____ Phone: (W) _____
(City, State, Zip) (County)

TYPE OF PLAN
- ☐ Initial Plan of Care
- ☐ Continued / Update
- ☐ Transition

CAP-MR/DD POPULATION
- ☐ At Risk
- ☐ ICF/MR Bed

FUNDING SOURCES
- ☐ SSI
- ☐ SA
- ☐ Medicaid
- ☐ Medicare
- ☐ CAP-MR/DD
- ☐ Thomas S. FBD ____
- ☐ Willie M.
- ☐ Insurance _____
- ☐ Other _____

DIAGNOSIS CODE AND DIAGNOSIS
(Complete all that apply)

AXIS I

AXIS II

AXIS III

AXIS IV

AXIS V

CURRENT MEDICATIONS AND REASONS FOR TAKING THEM
Date Completed: _____

THIS PLAN WAS COMPLETED WITH THE ASSISTANCE / INPUT OF THE FOLLOWING PEOPLE:

DMH 10/95

Name: _____

Record No.: _____

ADDITIONAL INFORMATION (required for Willie M. Services) ***Certification Date:***

Date for next TREATMENT/ HABILITATION PLAN: _____

Additional Day and Residential Provider Contacts (Name/Phone):

Biopsychosocial Formulation (Location/Date): _____

Assessments/Evaluations not described elsewhere:

Assessment:	Date:
Results:	
Assessment:	Date:
Results:	
Assessment:	Date:
Results:	

LEA/SOP _____ School: _____ Grade: _____

☐ Identified Exceptional Student? If Yes:

Area of Exceptionality _____ Year Identified _____

Individual Education Program:

☐ Current?	☐ Reviewed?	☐ Transition Plan? (14+)
☐ Individual Behavior Management Plan?	Describe:	
☐ Crisis Plan?	Describe:	

DMH 10/95

Name: _____

Record No.: _____

CLIENT LIFE CHART *(required for Willie M. Services)*

List in chronological order those ***events in the class member's life*** which have made a ***substantial impact*** on his/her normal growth and development. Types of events to be included:

- ***Developmental*** - Significant gains, or lack of them, in motor, intellectual, social and emotional skills as the child moves through childhood and adolescence.
- ***Environmental*** - Surrounding conditions/circumstances having a major impact on the child's growth & development.
- ***Clinical/Academic*** - Events having a major impact on the child's handicapping condition or having contributed significantly to our understanding of the child.

DATE:	AGE:	*SIGNIFICANT* LIFE EVENTS

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Name:
Record No.:

A) PERSON CENTERED PLAN

1) Strengths

According To _____ (client name) :

According To Others:

2) Choices

Choices Made By _____ (client name) :

Choices Made For _____ (client name) :

3) Current Preferences (Friends, Work, Home, Family, Choices, etc.)

Non-Negotiable:

Strong Preferences:

Highly Desirable:

4) Long Term Desires (where I want to live; what I want to do for a living; where I want to socialize; what I want to learn; relationships I want; who I want to help me; etc.)

DMH 10/95

Name: _____

Record No.: _____

B) DOMAINS

1) Living Arrangement / Housing / Residential

Assessment Given: _____ Date: _____

Future Assessments Needed: _____

Goal Statement _____

Strengths / Preferences (**Willie M.** "Needs")	Supports Needed / Strategies

Objectives To Achieve Client Goal	Projected Date Of: Implementation	Projected Date Of: Accomplishment	Responsible Person(s)

Name:
Record No.:

2) Vocational / Day

Assessment Given: _____ Date: _____

Future Assessments Needed: _____

Goal Statement _____

Strengths / Preferences (Willie M. "Needs")	Supports Needed / Strategies

Objectives To Achieve Client Goal	Projected Date Of: Implementation	Projected Date Of: Accomplishment	Responsible Person(s)

DMH 10/95

Name: _____

Record No.: _____

3) Educational

Assessment Given: _____ Date: _____

Future Assessments Needed: _____

Goal Statement _____

Strengths / Preferences (**Willie M.** "Needs")	Supports Needed / Strategies

Objectives To Achieve Client Goal	Projected Date Of: Implementation	Projected Date Of: Accomplishment	Responsible Person(s)

Name: _____

Record No.: _____

4) Medical / Health

Assessment Given: _____ Date: _____

Future Assessments Needed: _____

Goal Statement _____

Strengths / Preferences (Willie M. "Needs")	Supports Needed / Strategies

Objectives To Achieve Client Goal	Projected Date Of: Implementation	Projected Date Of: Accomplishment	Responsible Person(s)

Name: _____

Record No.: _____

5) Behavioral / Therapeutic Services (Psychiatric, Specialized Therapies)

Assessment Given: _____ Date: _____

Future Assessments Needed: _____

Goal Statement _____

Strengths / Preferences (**Willie M.** "Needs")	Supports Needed / Strategies

Objectives To Achieve Client Goal	Projected Date Of: Implementation	Projected Date Of: Accomplishment	Responsible Person(s)

Name: _____

Record No.: _____

6) Support Network / Family / Social

Assessment Given: _____ Date: _____

Future Assessments Needed: _____

Goal Statement _____

Strengths / Preferences (Willie M. "Needs")	Supports Needed / Strategies

Objectives To Achieve Client Goal	Projected Date Of: Implementation	Projected Date Of: Accomplishment	Responsible Person(s)

Name: _____

Record No.: _____

7) Leisure / Recreation

Assessment Given: _____ Date: _____

Future Assessments Needed: _____

Goal Statement _____

Strengths / Preferences (Willie M. "Needs")	Supports Needed / Strategies

Objectives To Achieve Client Goal	Projected Date Of: Implementation	Projected Date Of: Accomplishment	Responsible Person(s)

Name: _____

Record No.: _____

8) Legal Services

Assessment Given: _____ Date: _____

Future Assessments Needed: _____

Goal Statement _____

Strengths / Preferences (Willie M. "Needs")	Supports Needed / Strategies

Objectives To Achieve Client Goal	Projected Date Of: Implementation	Projected Date Of: Accomplishment	Responsible Person(s)

DMH 10/95

Name: _____

Record No.: _____

9) Crisis Services / Back-up Plan (Medical, Psychiatric, Behavioral)

Assessment Given: _____ Date: _____

Future Assessments Needed: _____

Goal Statement _____

Strengths / Preferences (**Willie M.** "Needs")	Supports Needed / Strategies

Objectives To Achieve Client Goal	Projected Date Of: Implementation	Projected Date Of: Accomplishment	Responsible Person(s)

Name: _____

Record No.: _____

10) Transitional Services

Assessment Given: _____ Date: _____

Future Assessments Needed: _____

Goal Statement _____

Strengths / Preferences (**Willie M.** "Needs")	Supports Needed / Strategies

Objectives To Achieve Client Goal	Projected Date Of: Implementation	Projected Date Of: Accomplishment	Responsible Person(s)

Name: _____

Record No.: _____

11) Case Management

Preferences for Case Manager Involvement:

Service Monitoring: (Method and Frequency)

Contact Schedule (Face-to-face, Phone, Correspondence)

Client:

Provider:

Family/Guardian:

Training Needs: (For Client, Family, Guardian, Providers)

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Name: _____

Record No.: _____

C) COST SUMMARY - Effective _____ / _____ / _____

List all services to be provided with the accompanying information. When payer is not Medicaid, enter a source cod under "Source". If there is not a code, use 13 or 14, and describe. Use V for visits; H for hours; D for days; and M for months under FREQUENCY. *Supplies and DME may be totaled here with details under Comments below.*

Source codes: 1 = Medicare 2 = Title XX 3 = Title III 4 = Insurance 5 = Area DD Funds 6 = State DD Funds 7 = Family/Friends 8 = Client (non-covered services only) 9 = Voc Rehab 10 = School System 11 = Thomas S. 12 = Willie M. 13 = Other _____ 14 = Other _____

SERVICE	CODE	PROVIDER AGENCY	FREQUENCY	FROM/TO	UNIT RATE	AVERAGE MONTHLY COST		
						MEDICAID	OTHER	SOURCE
					TOTALS:			

Comments: (Explanation of Waiver Supplies, DME, etc.)

Name: _____

Record No.: _____

D) COMMENTS

General

Family / Guardian Comments

E) SIGNATURES

CAP-MR/DD Client Choice Statement

I understand that I have the choice of seeking care in an intermediate care facility for the mentally retarded instead of participating in the Community Alternatives Program for the Mentally Retarded/Developmentally Disabled (CAP-MR/DD). I choose to participate in CAP-MR/DD.

Client / Guardian Signature _____ **Date:** _____

The following signatures confirm the involvement of individuals in the development of this assessment and plan of care. All signatures indicate concurrence with the services to be provided.

Title	Name / Signature	Date
Client		
Family / Guardian Representative		
Case Manager		
IAC Representative		
LEA Representative		

DMH 10/95

Name: _____

Record No.: _____

TREATMENT/ HABILITATION PLAN CONTINUATION PAGE

DOMAIN (From *PLAN*): _____

Assessment Given: _____ Date: _____

Future Assessments Needed: _____

Goal Statement _____

Strengths / Preferences **(Willie M. "Needs")**	Supports Needed / Strategies

Objectives To Achieve Client Goal	Projected Date Of: Implementation	Projected Date Of: Accomplishment	Responsible Person(s)

Family and Interagency Service Plan

The purpose of this form is to relate service goals to client needs, as identified by the IST Meeting Outline and Child Profile forms.

Date_____

Page _____ of _____

PEN-PAL
Family and Interagency Service Plan

Client Need	Goal	Intervention Service Providers	Estimated Completion Date	Date Completed

Date_____

Page _____ of _____

PEN-PAL
Family and Interagency Service Plan

Client Need	Goal	Intervention Service Providers	Estimated Completion Date	Date Completed

PEN-PAL System of Services
Community Services Menu—Part I

As a subset of the IST Plan, it is necessary to develop a crisis plan for each child and family being served.

Name_____ SSN_____

Services	To be provided by (staff)	No. of hours service requires	When (or how often)	Where service is to be provided	Initials of Service Rep. Responsible for this service
1. Crisis Coverage					

Parent/Custodian_____ Authorization through_____

Service Coordinator_____ Date of IST Meeting_____

PEN-PAL System of Services

Community Services Menu—Part II

As a subset of the IST Plan, it is necessary to develop a crisis plan for each child and family being served. This form itemizes the services by specific types.

Name_____ SSN_____

Services	To be provided by (staff)	No. of hours service requires	When (or how often)	Where service is to be provided	Initials of Service Rep. Responsible for this service
1. Case Management					
2. Home-based Services					
3. Psychiatric Consultation Care					
4. In-Home Support Monday—Friday ___a.m.__p.m.					
1. In-School Support Monday—Friday 5. ___a.m.__p.m.					
6. In-Home Support Saturday—Sunday ___a.m.__p.m.					
7. Recreational Activities Expenditures					
8. Residential					
9. Therapeutic Foster Care					
10. Other Wraparound					
11.					
12.					
13.					
14.					

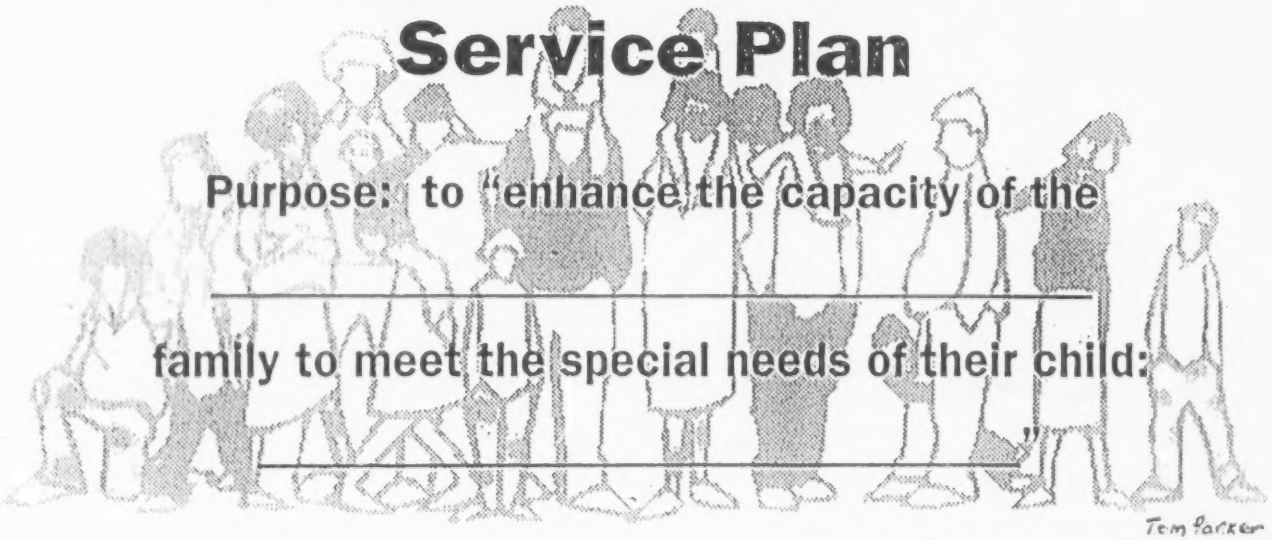
Parent/Custodian_____ **Authorization through**_____

Service Coordinator **Date of IST Meeting**_____

Note to reviewers: Which signature set is preferable?

Signature Date	Signature Date
Signature/Agency Date	Signature Date
Signature/Agency Date	Signature Date
Signature/Agency Date	Signature/Client, Parent, or Legal Guardian Date
Signature/Agency Date	Signature/Physician Date

Collaborative Family Service Plan



Purpose: to "enhance the capacity of the

_____

family to meet the special needs of their child:

_____."

PILOT DRAFT

MS-0779/MS 2-96

This plan meets the requirements of and serves as (check all that apply): | | Individualized Education Plan (IEP) | | Section 504 Plan | | Individual Treatment Plan (ITP)
| | Individual Family Community Support Plan (IFCSP) Type of Plan: | | Interim | | Initial | | annual | | Interim ITP | | Interim IFCSP | | other _____

A. Child/Youth Information

Name: _____ Birthdate: __/__/____ Gender: _____ Primary Language/Communication Mode _____

Current Address (Street, City, Zip): _____ County: _____ Phone: _____

Permanent Address (Street, City, Zip): _____ County: _____ Phone: _____

Social Security # _____ Child lives with: | | Parent(s) | | Foster Parent(s) | | Other household members | | Other family members | | Other _____

Custody Arrangements | | Mother/Father | | Mother | | Father | | Juvenile Court | | State Guardianship | | Other _____

B. Parent/Guardian Information

Name(s): _____ Relationship: _____

Address: _____

_____ County: _____

Telephone: day _____ evening _____

Primary Language/Communication Mode at Home: _____

Parent/Guardian Information

Name: _____ Relationship: _____

Address: _____

_____ County: _____

Telephone: day _____ evening _____

Primary Language/Communication Mode at Home: _____

Surrogate Parent

Name: _____ Address (Street): _____

City, Zip: _____ Telephone: day _____ evening _____

C. Health Information

Medical Emergency # _____ Emergency Contact Person: _____ Health Plan _____

Mental Health Diagnoses _____

AXIS Code I _____ AXIS Code II _____ AXIS III & AXIS IV (see attachment) AXIS V (GAF Score) _____

Primary Disability _____ State Code: (Provide Notice of Special Education Services) _____

ICD-9 or DSM-IV _____ Child's Medication _____ Child Determined Disabled By | | SSI | | State Medical Review Team

Child has accessed child/teen checkup: | | Yes | | No

D. School Information

School of Enrollment: _____ Grade: _____ District & #: _____ Telephone: day _____

Resident District (if different from enrolled): _____ School District # _____ ID# _ _ _ _ - _ _ _ - _ _ - _ _ _ _

E. Service Coordinator/Case Manager

Name: _____ Position: _____

Agency: _____ Address: _____ Phone: _____

IEP Manager Name: _____ Phone: _____

F. Planning Record

Date of Meeting __/__/__ Date of Last Comprehensive Assessment __/__/__ Date of Diagnostic Assessment __/__/__

Date Plan Written __/__/__ Next Comprehensive Assessment Due __/__/__ ITP Reviews __/__/__: __/__/__

Periodic Review Due __/__/__: __/__/__ (every 90 days) __/__/__: __/__/__

G. [ ] Parent/Guardian has been informed of all appropriate/applicable laws regarding their rights.

Family Name: _____ PILOTDRAFT Child's/Youth's Name: _____

Family Considerations

To be completed during the initial interview with parent/guardian/child

Parent/Guardian Information: Please assist the parent/guardian to discuss a typical day with the child; what goes well and what doesn't. What services has the family used in the past and what has been helpful to the child. What are seen as the child's strengths; concerns/needs for the child; what help the family, or the child needs in the months ahead; what the parent/guardian would like us to know about the child/family and who they would like to include in the planning meeting. **Please remind** the family that they may have representation from their own community of color to assist them with the process. (The information at the bottom of the page should be reviewed to help in the discussion process.)

Concerns for your child

getting around/mobility
communicating
learning/school
having fun with other children
getting along with other children
challenging behaviors or emotions
appropriate age/stage
assistive technology
other _____

Health concerns for your child

nutrition/eating
health or dental care
vision or hearing
pain or discomfort
sexually transmitted diseases
medications
chemical use/abuse

Concerns/needs for your family

meeting other families who have children who have similar needs
coordinating your child's mental health/medical care
finding out more about how different services work or how they could work better for you
planning or expectations for the future
more information about what resources might be available
transportation
child care
finding a support group
finding or working with people who can help you in your home or care for your child so you can have a break (respite)
housing, clothing, jobs, food, telephone
information or ideas for brothers, sisters, friends, relatives, others
money for extra costs of child's special needs
recreation
crisis assistance
legal issues
- family court
- juvenile court

other _____

Health concerns for your family

insurance
coordinating, making appointments
information about the disability or diagnosis
finding physicians/specialists

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Family Name: _____ PILOTDRAFT Child's/Youth's Name: _____

Family Considerations (Continued)

Child Information: Please assist the child/youth to talk about their strengths; friends; who they like to spend time with during the week, and at other times; what they like to do or would like to do if they could; any problems they are having, and want help with; what they would like to be different in the family next year; and anything they think is important we haven't asked about. Please share the list at the bottom of the page to assist the child/youth to identify interests/concerns or needs.

Child's/Youth's Interests

Friends
- girls/boys
- dating
- hanging out
- malls
- gang
- movies
- TV
- video

Music
- listen
- band
- orchestra
- chorus

Arts and Crafts
- build models
- sew
- paint

Sports
- bike ride
- roller blade
- ski
- ice skate
- tennis
- golf
- basketball
- wrestling
- soccer
- martial arts
- cross-country
- swim
- hockey
- football
- gymnastics
- hunting
- volleyball
- baseball

Family Activities
- church
- camping
- travel
- care for pet

Culturally Specific
- social groups
- meditation
- creative arts
- martial arts
- church activities

Clubs
- school
- Big Brothers/Sisters
- scouting
- Camp Fire Girls

Concerns

Friends
- bullying
- unlawful behavior
- alcohol/ other drug use
- issues related to gangs
- language/cultural differences

Family
- parents argue
- parents abuse each other, or siblings
- parents use of alcohol or other drugs
- lack of basic needs: food, clothing, shelter, protection

Self
- need help with homework
- not enough spending money

Health Concerns

Sexuality Questions
- sexual orientation
- sexually transmitted diseases
- pregnancy, prevention

Other
- weight loss, gain
- poor eating habits
- alcohol/ other drug use
- exercise
- often feel sad

Family Name: _____ PILOTDRAFT Child's/Youth's Name: _____

Team Members/Meetings Log

Reason for Meeting (e.g., Progress Review, IEP, etc.)

Name of Team Member	Relationship to Child	Agency	Telephone	Meeting Date __/__/__ Attended Yes	Attended No	Meeting Date __/__/__ Attended Yes	Attended No	Meeting Date __/__/__ Attended Yes	Attended No	Meeting Date __/__/__ Attended Yes	Attended No	Meeting Date __/__/__ Attended Yes	Attended No	Meeting Date __/__/__ Attended Yes	Attended No	Meeting Date __/__/__ Attended Yes	Attended No
	Parent																
	Parent																
	Pupil																
	Rep. of District																
	Special Ed. Teacher																
	Rep. of Gen. Ed. (K-12)																
																37	

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Family Name: _____ Child's/Youth's Name: _____

Collaborative Description of Child/Youth and Family Strengths

The identification of strengths and resources by members of the collaborative team will be made during the first planning meeting of the child and family.

I. The collaborative team members through a discussion with the child/youth and their family, will identify the strengths and abilities the team members have observed: These strengths and abilities should focus on positive relationships (family, friendships, others); school abilities (reading, writing, math, science); artistic and/or creative abilities and interests; recreational/leisure/family activities; participation and/or contributions by the child to the family home and community, including cultural community (household chores, and vocational/work related or volunteer activities). The discussion should also focus on family's hopes and dreams for the child and what they consider special about their family.

Family Name: _____ **PILOTDRAFT** Child's/Youth's Name: _____

Care Plan

Carefully consider and document data from all sources in the areas of presenting problems (include information from parents, youth, educational and diagnostic assessments):

☐ Intellectual/Cognitive Functioning	☐ Communication	☐ Motor Skills	☐ Emotional, Social & Behavioral Development
☐ Academic Performance	☐ Sensory Status	☐ Health/Physical Status	☐ Functional Skills

Description of present level of educational performance (in area checked above) and/or mental health functioning:

Concern/Need	Goal: # _____ of _____ Goals
1. Objectives/Strategies	Date(s) Reviewed _____/_____/_____ Progress Toward Objective #1 _____
2. Objectives/Strategies	Date(s) Reviewed _____/_____/_____ Progress Toward Objective #2 _____
3. Objectives/Strategies	Date(s) Reviewed _____/_____/_____ Progress Toward Objective #3 _____

MENTAL HEALTH SCALE: (1) Problem Has Worsened (2) No Progress (3) Progress (4) Considerable Progress (5) Accomplished (6) Discontinued

If these are educational goals and objectives, level of performance must be descriptive.

☐ Meets child/youth's current needs

☐ Does not meet child/youth's current needs. We will be in contact soon to schedule a meeting.

To fulfill mental health MA requirements, the concerns, goals, objectives and strategies have been reviewed together on _____(date).

_____ THERAPIST SIGNATURE

_____ CLINICAL SUPERVISOR SIGNATURE

_____ PARENT/GUARDIAN SIGNATURE

_____ CLIENT SIGNATURE

Family Name: _____ PILOTDRAFT Child's/Youth's Name: _____

Transition Program Planning

Transition Areas (All areas must be addressed):

- [ ] Jobs and Job Training
- [ ] Post-secondary Education and Training
- [ ] Community Living, Experience and Participation
- [ ] Recreation and Leisure
- [ ] Home Living/Daily Living Skills

Future Outcome/Goals:

Present Level of Educational Performance:

Needs: (Must address instruction, community experience and development of employment and post-school adult objectives; may include daily living skills and functional vocational assessment) (If no need in any mandated areas, provide rationale.)

Activities for Future Outcomes/Goals: (Identify who is responsible for each activity)	Date Reviewed_____/_____/_____ Progress

Instructional Annual Goal:
_____ of _____ Goals

Objectives:	Date Reviewed_____/_____/_____ Progress

Instructional Annual Goal:
_____ of _____ Goals

Objectives:	Date Reviewed_____/_____/_____ Progress

Family Name: _____ PILOTDRAFT Child's/Youth's Name: _____

Special Education and Related Services to Meet Goals and Objectives

Instruction or Service Provided	Site	Service Provider Name	Frequency Per Week	Total Minutes Per Week		Service		Funding Source
				Indirect	Direct	Start Date	Anticipated Duration	
General Education								

Altered School Day

Has youth's school day been altered? [ ] Yes [ ] No If yes, describe pupil's need for an altered school day as per requirement M. R. 3525. 2900 Subp. 3E

Extended School Year Services

Are extended school year services required for this pupil? [ ] Yes [ ] No (If yes, attach extended school year justification as described in M. R. 3525.2900 Subp. 1.G.)

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Family Name: _____ PILOTDRAFT Child's/Youth's Name: _____

Clinical/Therapeutic Services

Description of Services	Site	Agency & Phone # Service Provider	Frequency	Start Date	Anticipated Duration	Funding Source

Wraparound Services

Description of agency or family/support interventions	Person(s) or Community Resource and Phone #	Frequency	Start Date	Duration	Interagency funding source, responsibilities and expected change from the support/intervention provided

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Family Name: _____ PILOTDRAFT Child's/Youth's Name: _____

Adaptations in General and Special Education

Describe accommodations, including supplemental aids and services to be used in general and special education, that will be made available to permit successful education of the pupil. (e.g. grading, credits, staff, transportation, facilities, materials, equipment, technology, adaptive devices, curriculum, methods, coordination of support services, vocational services and equipment, and other services):

Describe any high school graduation requirements which need to be modified for this pupil.

Behavioral Interventions

Can the pupil follow the school district and building discipline policy? | | Yes | | No (Note adaptations above)

Is a conditional behavioral intervention procedure needed? | | Yes | | No

Describe in accordance with M. R. 3525.2900 Subp. 3.G and 5.A.(1).

Placement Determination: Least Restrictive Environment (LRE)

Review setting options with parents. Check (✓) option selected.

Federal Settings

____ I. Regular Class (instruction in general education; or outside of the general education classroom, or in resource room, for less than 21% of the school day)

____ II. Resource Room (outside the general education classroom for 60% or less of the school day and at least 21% of the school day)

____ III. Separate Class (outside of the general education classroom for more than 50% of the school day)

____ IV. Public Separate Day School (greater than 50% of the school day in separate facilities)

____ V. Private Separate Day School (at public expense for greater than 50% of the school day)

____ VI. Public Residential (greater than 50% of the school day)

____ VII. Private Residential (at public expense for greater than 50% of the school day)

____ VIII. Home-based/Homebound/Hospital (placement)

Provide rationale for setting selected and reasons for rejecting other options considered:

(LRE continued) Review setting options with parent(s). Check (✓) the option selected.

Federal Settings for Early Childhood Special Education Only

____ I. Early Childhood Setting (Programs for children without disabilities)
____ II. Early Childhood Special Education (ECSE) (General school buildings or community based)
____ III. Home (Child's family or caregivers)
____ IV. Part-time Early Childhood or Home/Part-time ECSE
____ V. Residential Facility (Public or private inpatient basis)
____ VI. Separate School (Public or private day school)
____ VII. Itinerant Services Outside the Home (No more than three hours per week)
____ VIII. Reverse Mainstream (Include 50% or more children without disabilities)

Provide rationale for the selection of setting:

Activities With Students Without Disabilities

For a pupil who is served in K-12 federal setting I. through VIII. above, check (✓) any activities in which the pupil will be participating with students who do not have disabilities.

	If *all* the areas below apply, check here.		
	Core Subject Areas of _____	Library	Recess
Art	Physical Education	Field Trips	Lunch
Music	Assemblies	Vocational	Other _____

If one or more of the above boxes ( ) are not checked, provide rationale.

List the extracurricular activities in which the pupil participates:

110 111

Parent(s) Child Guardian has participated in the development of this plan. _____

(3/18/97)

State of Hawaii
INDIVIDUALIZED FAMILY SERVICE PLAN

Plan Date ____/____/____
Plan Review Date ____/____/____

Name of Child/Youth _____ _____ _____ ____/____/____
Last name First name Middle I. Social security no.

School _____ Grade _____ Date of Birth ____/____/____ Sex ____ Language assistance needed (specify) _____

Child currently served by	Informed of rights? (parent initial)	Child ID #	Participant Name	Indicate if you are the Legal guardian (LG), Care coordinator (CC), DOE Administrator (A) or Designee (D)
___ DOE 504				
___ DOE IDEA H				
___ DOE IDEA B				
___ DOH IDEA H				
___ DOH CAMHD				
___ DOH CSHNB				
___ DOH DDD				
___ DOH PHNB				
___ DHS _____ (specify)				
___ Judiciary _____ (specify)				
		Role		
Other Participants:				

Signatures: Child/Youth _____ Date ____/____/____ Do you agree with this Plan? (Y/N) _____

Parent _____ Date ____/____/____ Do you agree with this Plan? (Y/N) _____

Legal Guardian _____ Date ____/____/____ Do you agree with this Plan? (Y/N) _____

HOME / FAMILY (please indicate the following as they occur within the Home/Family domain: 1) child/youth developmental status, 2) child/youth & family strengths relevant to this Plan, and 3) child/youth & family concerns and priorities)

SCHOOL / EDUCATION (please indicate the following as they occur within the School/Education domain: 1) child/youth developmental status, 2) child/youth & family strengths relevant to this Plan, and 3) child/youth & family concerns and priorities)

COMMUNITY / WORK / LEISURE (please indicate the following as they occur within the Community/Work/Leisure domain: 1) child/youth developmental status, 2) child/youth & family strengths relevant to this Plan, and 3) child/youth & family concerns and priorities)

HEALTH (please indicate the following as they occur within the Health domain: 1) child/youth developmental status, 2) child/youth & family strengths relevant to this Plan, and 3) child/youth & family concerns and priorities)

Add Sep. Domain for peer

GOALS, OBJECTIVES & SERVICES (please consider the domains of home/family, school/education, community/work/leisure and health when providing the following information)

Long term goal _____

Short term objective _____

_____

How we will know the objective was achieved? _____

	Start Date	Frequency	Anticipated Duration	Funding Source
Service/activity_____	___/___/___	_____	_____	_____

Method _____

Setting _____

Person/agency responsible _____

	Start Date	Frequency	Anticipated Duration	Funding Source
Service/activity_____	___/___/___	_____	_____	_____

Method _____

Setting _____

Person/agency responsible _____

	Start Date	Frequency	Anticipated Duration	Funding Source
Service/activity_____	___/___/___	_____	_____	_____

Method _____

Setting _____

Person/agency responsible _____

	Start Date	Frequency	Anticipated Duration	Funding Source
Service/activity_____	___/___/___	_____	_____	_____

Method _____

Setting _____

Person/agency responsible _____

positive education program

CONNECTIONS

Intersystem Planning Team - Individualized Service Plan

Client's Name:_____ DOB:__/__/__ Primary CSP:_____

Parent/Guardian:_____ DOE:__/__/__ IEP in effect: ☐ No ☐ Yes TYPE:_____

Change: ☐ Client's Address ☐ Parent/Guardian Address ISP Date:__/__/__ NEXT SCHEDULED MEETING

To: _____ Phone: _____ DATE:_____

Description of the specific needs based on diagnostic assessment, referral information, client-generated information.

OHIO

Description of strengths, assets, and supports and how they will be utilized in treatment.

Medications (list all, including dosage and frequency)

Services needed and frequency. **Medicaid Eligible:** ☐ No ☐ Yes Insurance Provider_____ Number_____

SERVICE		PROVIDER/CONTACT		FREQUENCY	Total No. of Units this Qtr.	Start Date	End Date	Funding Source* *Note shared payment & Amount
PRIMARY COMMUNITY SUPPORT PROGRAM		CONNECTIONS						

Use PEP Track Code Tables

Community Support Planning Team - The undersigned have reviewed this document and agree to it.

Date I hereby give permission to Connections primary CSP, listed below, to release confidential information necessary for referral and onging treatment planning to the above-named providers. This permission expires in 90 days, and may be revoked at any time by the parent, legal guardian or client (18 yrs or older). Information may only be re-released with written authorization.

__/__/__ Parent/Guardian_____

__/__/__ Student _____

__/__/__ Primary CSP _____

__/__/__ Other _____

__/__/__ Other _____

__/__/__ Other _____

__/__/__ Other _____

__/__/__ Other _____

__/__/__ Other _____

__/__/__ Other _____

Reviewed and approved in accordance with ODMH Rule 5122-23-14

__/__/__ Clinical Supervisor _____

Reviewed and approved in accordance with ODMH Rule 5122-27-04 (O)(1-4)

__/__/__ Clinical Director _____

[redacted]ce M[redacted]. Ph.[redacted]

A= Prevent child's removal from biological/adoptive family B= Return to family from out of home placement C= Maintain or locate alternative community placement D= Independent living

Client's Name: _____ Master Goal: _____ ISP Date: ___/___/___

Current Need/Problem	Target Date for Achievement ___/___/___
Treatment Goal # _____	
Measurable Steps and Timeframes for Achievement of Goal:	

Current Need/Problem	Target Date for Achievement ___/___/___
Treatment Goal # _____	
Measurable Steps and Timeframes for Achievement of Goal:	

Current Need/Problem	Target Date for Achievement ___/___/___
Treatment Goal # _____	
Measurable Steps and Timeframes for Achievement of Goal:	

Current Need/Problem	Target Date for Achievement ___/___/___
Treatment Goal # _____	
Measurable Steps and Timeframes for Achievement of Goal:	

WHITE - Student File CANARY - CSP PINK - Parent

PART E

Child Name: _____

SEVERITY RATING*	PRESENTING PROBLEM	DURING THIS PERIOD	DATE →	Status Indicators True (+) / False (-)			
	01 = Abandoned	No other abandonment occurred (caretaker left, rejected from home)					
	02 = Academic Problem	Received passing grades					
	03 = Alcohol/Chemical Dependency	No evidence of alcohol or drug use found					
	04 = Assaultive	No assaults reported					
	05 = Attention Seeking Behaviors	Exhibited fewer attention seeking behaviors					
	06 = Chronic Physical Problem	Received and complied with appropriate medical care					
	07 = Communication Problem	Appropriate communicative behavior increased					
	08 = Compulsive Behavior	Compulsive behaviors decreased					
	09 = Cult Involvement	No evidence of cult contact or cult related behaviors					
	10 = Defiant Behavior	Decrease in defiant behavior reported					
	11 = Delusions	Demonstrated decrease in delusional behavior					
	12 = Depressed Mood	Increase in positive affect behaviors reported					
	13 = Destructive to Property	No evidence of property destruction reported					
	14 = Developmentally Delayed	Demonstrated increase in independent living and functional skills					
	15 = Disorientation in Thinking	Demonstrated decrease in disoriented thought					
	16 = Disruptive	Exhibited fewer disruptive behaviors					
	17 = Domestic Violence	No instances of domestic violence reported					
	18 = Eating Disorder	Exhibited fewer or less intense disordered behaviors					
	19 = Firesetting	No evidence of fireplay or firesetting behavior					
	20 = Gang Involvement	Decrease in interaction with gang members reported					
	21 = Hearing Impaired	Received and complied with appropriate auditory assistance					
	22 = Hyperactive Behavior	Lower levels or intensity of hyperactive behavior reported					
	23 = Impulsive Behavior	Increase in demonstrations of thought before action reported					
	24 = Inattention (Poor Concentration)	Decrease in inattentive behavior reported					
	25 = Incontinence	Decrease in incontinent instances reported					
	26 = Learning Problem	Improvement in skill instruction &/or skill acquisition reported					
	27 = Lying	Decrease in number or intensity of lying events reported					
	28 = Memory Impairment	Increase in environmental accomodations to memory impairment demonstrated					
	29 = Neglected	Evidence of decreased level or instances of neglect					
	30 = Nightmares	Decrease in number or intensity of nightmares reported					
	31 = Overanxious	Evidence of lowered anxiety reported or demonstrated					

SEVERITY RATING*	PRESENTING PROBLEM	DURING THIS PERIOD	DATE →	Status Indicators True (+) / False (-)			
	32 = Physically Abused	Reported no instances of abuse, increased expression re abuse, or increased coping behavior re abuse					
	33 = Poor Peer Relations	Exhibited improvement in appropriate interaction with peers					
	34 = Poor Self-Esteem	Exhibited decreased self-derogatory statements or increased efforts to attempt new challenges					
	35 = Runaway	No runaway incidents reported					
	36 = Hallucinations	No hallucinative behavior reported					
	37 = Seizures	Decrease in number or intensity of seizure activity reported					
	38 = Self Care/ Hygiene Failure	Demonstrated improvements in hygiene or self care					
	39 = Self Mutilation	Decrease in self mutilating behavior reported					
	40 = Sensory/Motor	Sensorymotor programming provided or improvement in sensory/motor functioning reported					
	41 = Sex Offender	1) Appropriate therapeutic intervention provided 2) No sex offenses reported					
	42 = Sexual Disorder	1) Appropriate therapeutic care provided 2) Improvement in disordered sexual behavior reported					
	43 = Sexually Abused	Reported no instances of abuse, increased expression re abuse, increased coping behavior re abuse					
	44 = Sibling Conflict	Decrease in number or intensity of sibling conflict events reported					
	45 = Sleep Disorder	Improved sleeping behavior reported					
	46 = Social Withdrawal (Isolation)	Evidence of increases in interactive behavior					
	47 = (This number is no longer used)						
	48 = Speech/ Language	Demonstrated improvements in language behavior and/or articulation					
	49 = Stealing	Decrease in number or intensity of stealing events reported					
	50 = Suicidal Thoughts	Decrease in number or intensity of suicidal thoughts reported					
	51 = Suicide Gesture Attempt(s)	No suicide attempts reported					
	52 = Suicide Gesture(s)	Decrease in number or intensity of suicide gestures reported					
	53 = Temper Tantrums	Decrease in number or intensity of tantrums reported					
	54 = Truancy	Decrease in percentage of truant school days recorded					
	55 = Unrealistic Fears	Decrease in number or intensity of unrealistic fear expressions reported					
	56 = Vandalism	No evidence or suspicion of involvement in vandalism reported					
	57 = Visual Impairment	Received and complied with appropriate visual assistance					
	58 = Cruelty to Animals	No instances of cruelty to animals reported					
	59 = Separation Anxiety	Demonstrated increases in independent behavior during separation events					
	99 = Other _____						

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INDIVIDUAL FAMILY CARE PLAN

Review

Kapi`olani HealthHawai`i Big Island Behavioral Health Services
Carter Professional Center #A-11, 65-1230 Mamalahoa Highway, Kamuela, Hawaii 96743
Phone: (808) 885-5505 Fax: (808) 885-6442

(All Incomplete Forms will be Returned)

CLIENT: _____ Today's Date: _____

SSN/ID No. _____ DOB: _____

Strategies (List strategy/goal it relates to.)	Date Implemented or if no date, explain.	Measurable Objectives	Progress Toward Objectives

CURRENT NEEDS (Present Challenges)

STEP DOWN PLAN	CONTINGENCY PLAN	TRANSITION PLAN

DIAGNOSIS

AXIS I: Code #: _____ Description: _____

Code #: _____ Description: _____

AXIS II: Code # _____ Description: _____

AXIS III: _____

AXIS IV: _____

GAF SCORE- Current: 128 ___ **GAF SCORE**-Past year: _____ **CAFAS SCORE:** _____ 60

MISSOURI

THE COMMUNITY OF INDEPENDENCE
COORDINATED SERVICES PLAN

Name: _____ Birthdate: _____ Grade: _____ Male / Female (Circle One)

Social Security #: _____ Medicaid #: _____ Race: _____

Address: _____ Phone: _____
Street Address City State Zip

School District: _____

Home School: _____ Attending School: _____

Legal Guardian: _____ Biological Parent: _____

☐ Reunification ☐ Guardianship ☐ Adoption ☐ Self-Support & Independence
☐ Initial ☐ Continuation ☐ Interim ☐ Initial/Transfer
☐ Change of Placement ☐ Pre-Vocational ☐ Early Intervention ☐ Dismissal

Date: _____ Primary Service Coordinator: _____

Service Coordinator's Agency: _____ Phone: _____

Key Plan Dates: Initiation: __/__/__ Expiration: __/__/__ Review: __/__/__ Diagnostic Summary: __/__/__

Eligibility and Source(s): _____

_____

_____

Collaborating Agency: _____ Coordinator: _____ Phone: _____

Collaborating Agency: _____ Coordinator: _____ Phone: _____

Collaborating Agency: _____ Coordinator: _____ Phone: _____

Collaborating Agency: _____ Coordinator: _____ Phone: _____

Collaborating Agency: _____ Coordinator: _____ Phone: _____

Services	Location	Min Per Day/Week	Status of Service	Implementor	Funding Source
1.					
2.					
3.					
4.					
5.					
6.					

Supplemental Aid or Support Services:

Family Support Assessment (Concerns; Priorities; Resources):

Family Assessment? ☐ Included w/permission ☐ Permission refused ☐ Obtained but not included

Transition Plan Included? **YES (see attached)** **NO**

Justification for Placement

☐ **During the development of the individual plan, the multidisciplinary team discussed alternative services and received recommendations from each team member. Educational interventions in the regular classroom and/or least restrictive special education services are documented in the Student Diagnostic Summary Report. Due to the diagnosed disabling condition(s), essential elements such as individualized instruction and adaptive equipment/materials are necessary for academic progress. These services are provided in the least restrictive environment.**

☐ **DFS Statement**

☐ **DMH Statement**

☐ **VR Eligibility met**

Present Level of Performance Statement (Include strengths, current level, unique developmental needs):

Objective #: _____
Domains: ☐Family ☐Social ☐Educ/Voc ☐Psych/Emotional ☐Medical ☐Safety ☐Financial ☐Residence

Need: _____

Objective/Goal: _____

_____

Method/Intervention: _____

_____

Timeline: Initial __/__/__ Review __/__/__ Met __/__/__ Implementor: _____

Criterion: ☐Observation ☐Reports ☐Frequency Measure ☐Other _____
☐Assessment ☐Demonstration ☐Product _____

Objective #: ____ _____
Domains: ☐Family ☐Social ☐Educ/Voc ☐Psych/Emotional ☐Medical ☐Safety ☐Financial ☐Residence

Need: _____

Objective/Goal: _____

_____

Method/Intervention: _____

_____

Timeline: Initial __/__/__ Review __/__/__ Met __/__/__ Implementor: _____

Criterion: ☐Observation ☐Reports ☐Frequency Measure ☐Other _____
☐Assessment ☐Demonstration ☐Product _____

Objective #: _____
Domains: ☐Family ☐Social ☐Educ/Voc ☐Psych/Emotional ☐Medical ☐Safety ☐Financial ☐Residence

Need: _____

Objective/Goal: _____

_____

Method/Intervention: _____

_____

Timeline: Initial __/__/__ Review __/__/__ Met __/__/__ Implementor: _____

Criterion: ☐Observation ☐Reports ☐Frequency Measure ☐Other _____
☐Assessment ☐Demonstration ☐Product _____

Objective #: _____
Domains: ☐Family ☐Social ☐Educ/Voc ☐Psych/Emotional ☐Medical ☐Safety ☐Financial ☐Residence

Need: _____

Objective/Goal: _____

_____

Method/Intervention: _____

_____

Timeline: Initial __/__/__ Review __/__/__ Met __/__/__ Implementor: _____

Criterion: ☐Observation ☐Reports ☐Frequency Measure ☐Other _____
☐Assessment ☐Demonstration ☐Product _____

Committee Member Name	Role	Attended Meeting
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N

Comments:

Statement of Confidentiality: Information will be maintained and released in accordance with the regulations i the Family Educational Rights and Privacy Act (FERPA) of 1974. Permission is granted for the information o this document to be shared only with named collaborating agencies.

Parent / Legal Guardian Signature

Date